The RHODE ISLAND MEDICAL JOURNAL

VOL. XXX FEBRUARY, 1947 NO. 2

# RHODE ISLAND'S WATER POLLUTION PROBLEM*

PAUL C. COOK, M.D.

The Author. *Paul C. Cook, M.D., of Providence. President, Providence Medical Association, 1946.*

THE HIGHLIGHT for the Association the past year was the return of our colleagues from service with the armed forces following the conclusion of World War II. Our membership as we start the year 1947 is almost entirely that of physicians in civilian practice again, and we rejoice upon the return of these men to our community.

The Association has been mindful of its obligation to the men who left here to serve with the military forces. We have done what we could to help them re-establish their practice. Public display announcements have been carried in the *Providence Journal* at various times to list the office address and telephone number of the returned physician. Our committees have met with municipal authorities in the matter of zoning restrictions in areas where physicians have desired to locate, and with real estate agencies to seek possible office spaces. The exemption from Association assessment maintained during the war service was continued for each returning physician for a period of six months after he established civilian work.

These activities are not necessarily great, but they reflect a conscientious effort on the part of the Association to help solve some of the problems of the physician-veteran.

To relate all the various activities of the Association during the year would entail repetition of what will be presented to you in detail through various committee reports. However, I would like to recall to your attention some of the more important items. We have instituted action by the State Society for the development of better medical-dental relations, we have studied the possibility of a central telephone exchange, reports have been made to you on the question of fees for home and office visits in our district and of physicians available for day or night emergency calls. We have initiated action towards a fitting celebration of the Association's centennial next year, and our old original records have been microfilmed for better preservation. The Association's action in arousing the community to the need for more effective control of smoke pollution has resulted in civic action and more recently in the introduction in the Providence City Council of a better smoke ordinance.

The most important part of our activity, the presentation of scientific papers to our members, has received first consideration throughout the year. We have been fortunate in having had some outstanding speakers—Major General Hawley and Dr. Shields Warren come to mind as we look back. There has been an effort made to include speakers of our own locality, and those representative of our own institutions, on the programs. As in past years, we have had more material than we could use, and have been forced to defer some desirable papers to a later date. One of our most enjoyable evenings was the April meeting, when several of our members, newly returned from service with the armed forces, gave reports of their medical work and experience in widely scattered sections of the globe. The attendance at the meetings has been good. We have appropriated funds for the opening of the Library three nights each week for the convenience of the members.

In addition to the social gatherings that conclude our monthly assemblies at the Medical Library, our efficient Committee on Entertainment staged one of the finest annual dinner programs in our history. It is to be hoped that these functions will continue to expand and bring into closer contact socially the physicians of the Providence area.

### *Pollution of State Waters*

In the time at my disposal this evening I am go-

*continued on next page*

*Presidential address delivered before the Providence Medical Association at its 100th Annual Meeting, at Providence, January 6, 1947.

ing to consider a subject in which the Association has been officially interested during the past year through an active committee, and one which individually concerns us all, that of pollution of our State waters.

I wish to express my gratitude to Mr. S. Robert Preston for making available to me the records of the State Planning Board and to the *Providence Journal* for granting access to their files in the preparation of this talk.

The recent publication of the proposed plan of the Department of Health is most welcome as it promises to be a step toward abatement of this dangerous health situation.

Rhode Island is more closely associated with its waterways than any other state, surrounding Narragansett Bay as it does, and being endowed by Nature with an abundance of small rivers and streams. Both its tidal and fresh waters have been of great importance in the life of the State, economically and in other ways.

In rural districts water pollution is of little consequence. Streams can handle the small amount of industrial waste from scattered small mills without damage to themselves, sanitary waste seldom finds its way into them, and these waterways remain economic assets without sacrificing their recreational and health value.

The accumulation of population and industry in the relatively small area of our State has placed a burden on our waterways that has very seriously changed their character. They have, in many cases, been unable to cope with the amount of waste that has been put in them, and increasing amounts of industrial and sanitary sewage have been channelled through them into Narragansett Bay. I do not consider it necessary to give here extended proof of the pollution of the Bay and many of the inland waterways of the State. The facts are self evident. We all know that the upper Bay is grossly polluted. The most casual inspection leaves no doubt of it. The water is foul, offensive to sight and smell, often gleaming with oil scum, the shore line littered with garbage, smeared with oil, with unmistakable evidence that untreated sewage has been poured into it, particularly along the eastern shore below the mouth of the Seekonk. At low tide the conditions do not bear too close description—the sewage outlets of water-front estates, illegally piped into the bay are then plainly evident. Recently twenty-three such outlets were counted along a half-mile stretch of shore in what is considered a desirable residential section. They are a minor source of pollution, and are important mainly as they typify the disregard of the laws of the State in this respect. The main sources of contamination of the Bay can be classified in different ways. Geographically, they are sources within and without the State, and are of the same nature whether they arise in Massachusetts, in the industrialized Blackstone Valley, emptying industrial and sanitary sewage into the Blackstone River and the Seekonk, or in the Taunton and Fall River areas, discharging into Mount Hope Bay, or whether they originate wholly within our own State.

A considerable source of pollution is the dumping of refuse and sewage from ships in the Bay, particularly naval vessels. The Navy's shore installations at Quonset and Davisville have sewage treatment plants, but the large and small craft, from airplane carriers down, that are or may be berthed at Quonset or Newport, with crews well into the thousands, dispose of all their refuse in the State waters.

### *Types of Pollution*

Another geographical division might be between waterways designed for public use as a source of drinking water and waterways used for industrial purposes. To give credit where possible, there is no evidence of any pollution of our public water supplies of any consequence. Classifying pollution by the nature of the polluting substance, we would have three types: that due to sanitary sewage, municipal or domestic; industrial, comprising the waste products of numerous types of industry that exist in Rhode Island, contributive in greater or less degree to stream and bay pollution; and lastly oil pollution, which should be considered separately from sanitary and industrial sewage. All these factors contribute to the condition which was so well summed up in the masterly statement in the editorial in the RHODE ISLAND MEDICAL JOURNAL for June, 1946: "It can be taken for granted that Narragansett Bay is a nasty place." The causes of this increasing pollution may be summarized by saying that population and industry have far outstripped provisions made for the healthful and decent disposal of their waste products.

We might at this point briefly consider the oil problem. Some thirty years ago the various oil companies began to establish their plants on the shores of the upper Bay, until now Providence is the major oil port of the northeastern seaboard. Immediately a special type of pollution was introduced. Industrial and sanitary sewage render water unfit for marine life by their toxic action or by reducing the water's oxygen content. Oil is more destructive, both while on the surface, as a film, when the immature oysters in their free-swimming form are killed by it, and when it has settled to the bottom to unite with other contaminants and form a sludge that kills or renders unfit for food any shell fish that comes in contact with it. In 1939 the sub-committee on Wild Life of the State Planning Board reported the effects of oil polution on our marine life. Leased oyster grounds had dimin-

ished to less than one-fourth of their former extent, the financial return to this industry had fallen from a peak of two million dollars to about five hundred thousand, our other fisheries had suffered proportionately. Oysters had failed to propagate in our polluted waters, and spawn had to be imported from cleaner out-of-state sources. Surface oil had killed more of our wild ducks than all the hunters. There had been a continuous expansion of the contaminated area of the upper Bay, transforming "the once clean bottom to a mucky, foul smelling mud unfit for normal marine life of any sort. The range of foul bottom extends in places far beyond the restricted water zone."

The economic loss occasioned by oil and other contamintants of the Bay includes damage to the recreation industry, important in this State. Polluted water does not attract vacationists. Already, this business has suffered, and will suffer more if the present tendency continues. Aside from the financial loss, there is a more serious one: our residents are being denied, more and more, opportunities for healthful recreation that are theirs, of right, as citizens of a State with unequalled natural resources for many types of play.

Our other varied Rhode Island industries are being handicapped as well by water pollution--there is an inadequate supply of reasonably good water for their processes, and the means of disposal of their waste products is also inadequate. For these reasons Rhode Island is not an attractive place for new industries. None have come here for many years, and the likelihood of any braving the present conditions is slight.

The physical equipment in the State for the handling of industrial and sanitary sewage comprises sewage plants in Providence — handling a part of Pawtucket's sewage and that of North Providence; in East Greenwich; East Providence, serving a part of that town; Bristol, Warren and West Warwick. Cranston is building a plant which, at present, is partially completed and is in use for part of that city. The only means of disposal for industrial wastes has been to empty them into municipal sanitary sewers or convenient waterways. Industrial and sanitary sewage disposal are different problems: industrial wastes are chemical solutions and in the main interfere with the bacterial action which is the basis of sanitary sewage treatment. Industrial waste, then, can only be emptied safely into our sewage plants in limited amounts. The disposal of oil finding its way into sanitary sewers is limited by the same factor. The statement in the recent department of health plan for pollution abatement that the main sewage treatment plan of the State, that of Providence, is only 50 per cent as efficient as expected, is very disturbing. One cannot but wonder if other unsuspected health hazards exist.

### *State Law on Pollution*

The law governing pollution was passed in 1920, and has been subsequently amended. It has certain loopholes, the more important of which are the exemption of some communities from its provisions—Newport, Jamestown and New Shoreham —and the fact that it cannot apply beyond the State borders. It is weak in that thirty days' notice is required before action against an offender can be begun. With these exceptions it is a very comprehensive law. If a boy cleans a chogsett on the rocks and throws the head in the Bay he has committed an illegal act. Enforcement is the function of the Sanitary Engineering Division of the Department of Health, whose duty it is to investigate any known or suspected violation, on its initiative or on complaint, to hold hearings, make findings of fact, enter corrective order, and to consult with and advise individuals, corporations or municipalities. Prosecution of persistent offenders is delegated by the Division to the Attorney General's office. The validity of the rulings of the Division has been established by the Supreme Court. Soon after

*continued on next page*

**For years the pollution of our waters has been getting increasingly worse. The situation is now so serious that it has become a menace to the public health; large areas of Narragansett Bay have had to be closed off from shell fishing; property values, bathing and recreational facilities along our shores are adversely affected. We can ill afford to tolerate this ugly condition any longer. A concerted effort must be made under the State's auspices to cope with the problem *now*.**

**Realizing the seriousness of the situation, shortly after I became Governor I directed the State Department of Health to make a detailed study and investigation of our entire pollution problem. This has been done and a complete report of existing conditions and suggested remedies is now available to us. I urge you to give it your best study and prompt attention. The welfare of our people demands that corrective action be taken in this matter without delay.**

**. . . the . . . recommendations contained in this report are practical and sound. They should be adopted. A sensible and workable plan has now been suggested. Further delay would be inexcusable and I therefore strongly urge prompt action.**

**GOVERNOR JOHN O. PASTORE, *in his Inaugural Message to the Rhode Island General Assembly, at its January Session, 1947.***

passage of the law, the Board of Purification of Waters, predecessor to the present Division, enacted regulations to prevent oil contamination. These rules were appealed by the oil companies and upheld. Oil is also under Federal statue, the Anti-Pollution Act of 1936, and a coast guard vessel is on duty in the Bay again, after absence during the war, to enforce this law. There have been several bad spills in the past few months, and the need for strict State and Federal supervision is evident. The accidental nature of this type of pollution does not excuse the offenders. Railroads and automobile drivers are not exempt from suit for damages resulting from accidents. It is fair to say that two of the oil companies whose plants are in the upper Bay are cooperating well and have installed equipment to lessen this hazard.

It would be interesting to know whether the State law as it applies to industrial and sanitary sewage could be enforced. In the published report of the Department of Health plan previously mentioned the Division of the Sanitary Engineering, the agency of enforcement, states that as to areas other than the Blackstone-Moshassuck district, "It is felt that with the exception of Mt. Hope Bay, the existing pollution law can be applied with satisfactory results." In Snow White and the Seven Dwarfs, our little friend Dopey did not talk. Nobody knew whether he could as he had never tried.

The present unpleasant situation is the result of non-enforcement of our laws plus pollution from sources not covered by these laws—from exempted districts within the State, and from without the State. Our laws need revision on these points, and probably on others as well. It is self-evident that the problem is more than Statewide. Close cooperation with our neighboring states is essential, but it is wrong to argue that Rhode Island cannot clean her waters unless other states cooperate with her, when little effort is made to initiate such action and cooperation. We have immediate tasks to undertake within the State. We have carried tolerance too far when we condone the action of communities that have shirked their responsibilities in Statewide antipollution efforts, and which continue to dispose of their sewage in a manner that is a continual menace to the health of other parts of the State, that makes our streams and waters unfit for any recreation, and that causes extensive property damage. The most conspicuous offender in this respect you all know—the City of Pawtucket. In 1929 Pawtucket was ordered to build a sewage disposal plant, after due hearings had been held and the city found guilty of pollution; but after eighteen years the plant is still unbuilt, and every day from 20 to 30 million gallons of untreated sewage is poured from the mains into the Blackstone and Seekonk Rivers, to empty into the Providence River and Narragansett Bay. Let our State clean up our share of the Blackstone River, and also cooperate to the fullest with Massachusetts toward the end of abating the pollution in their share. There is little incentive for the oil or other industries to strive for betterment of their waste disposal conditions when the governing body—the State—tolerates such flagrant violations.

### *Vital Points*

If we look for reasons why our sanitary laws have had so little enforcement, we quickly come to some vital points. Personnel for enforcement is limited. The problem is large and complex, interlocking with other states, involving many industries of many kinds, all of theim important to greater or less degree to our economy. They provide the payrolls that are our largest financial resource. The magnitude of the problem and the real importance of possible violators, private corporations or civic communities, is one reason. Lack of sustained official interest is another and an important reason. All too often such interest has been displayed only around the first Monday in November. The main reason, however, comes from the deeper strata of our society, rather it does not so come. There has been insufficient arousing and maintaining of public interest in the problem. It affects us all. We are being deprived of our right to enjoy and benefit from Narragansett Bay and our waterways. They should be a means of health and recreation unsurpassed in any other state, a source of livelihood for many. We are forced to endure instead polluted waters, increasingly impossible for recreation, and definite menaces in many ways to our health. And there is no need for it. Other communities are learning how to adjust their industrial and sanitary problems so that their waters are again becoming health and recreational assets, instead of liabilities, without the sacrifice of industry. If we are to make progress toward that goal in Rhode Island, we must work for it. We are members of a profession that believes that diagnosis is essential for proper treatment. Diagnosis means study of the case, learning the facts involved. That is essential here. A comprehensive survey of the water potentials of the State, a similar survey of the present and possible future industrial and sanitary demands upon them, with planning to adapt our industry, present and future, to its basic water needs is required. It is necessary for communities as well as tailors to fashion their suits according to their material.

Similarly, a sanitary survey of the Bay to determine the present extent and degree of its polluted area is very desirable. The medical profession would be greatly pleased to find that pollution has

not extended beyond its known limits. If there has been any such extension, as has been stated in the committee report mentioned, appropriate measures to eliminate health hazards in our fisheries and recreational use should be taken. We feel that the citizens of this State have a right to know the present condition of their Bay.

The proposed Health Department plan seems excellent in many respects. We here are interested in the problem primarily from a health standpoint, and must depend on members of another profession, that of sanitary engineering, to determine the ability of any plan, if properly carried out, to produce and maintain necessary health standards. If on due study this plan promises to meet these requirements, it will have the whole hearted support of this and all other medical societies within the State and of all individual members of our profession as well.

### *Public Interest Important*

Most important of all, in an attack on the problem, is the arousing of public interest to the point that enforcement of suitable laws is possible. No law is stronger than the public opinion that upholds it. There is no question that the laws regarding theft and murder are put in the statute books to be enforced. Our citizens have definite convictions on these questions, and their voice is strong for proper punishment of those guilty of these crimes. So far, however, they have not vigorously demanded the return of their rights to enjoyment of state waters, taken from them by pollution. In the twenty-six years since the anti-pollution law was enacted there have been many resolutions, surveys, meetings of protest, and promises concerning pollution abatement. To glance back over the recent record: in May, 1937, the Health Department closed 13 per cent of the area of Narragansett Bay to the taking of shellfish, because of pollution; in 1939 Governor Vanderbilt agreed that the Bay must be cleared up; in 1941 Governor McGrath and the State Planning Board objected to the pumping of sewage into the bay from the Navy's housing project at Middletown; Barrington citizens urged action on pollution and named Central Falls, Newport, Jamestown, Pawtucket, Middletown and Fall River as offenders. Governor McGrath said the State would cooperate in the drive to end bay pollution, and suggested a series of State-owned sewage treatment plants, and the Providence City Council condemned lax enforcement of present laws and also noted that "a lack of proper plans to eliminate pollution" constituted a health menace. In 1942, the Fall River City Council prepared to take action on Mount Hope Bay pollution, the Bristol County Lions Club continued its drive against pollution with 47 supporting organizations, a Newport pier was posted following the finding of raw sewage on the nearby shore. In 1943 the State Health Department closed South Cove, Wickford, to shellfishing and investigated the dumping of raw sewage there, the Bristol Town Council invited the Division of Sanitary Engineering to participate in an open meeting to start investigation of harbor pollution—an invitation that was declined.

There is no need of adding to this list. The coordination of these different organizations and others interested is desirable: the sportsmans' organizations, the fishermen and yachtsmen, all our public-minded groups might be so correlated that their efforts would be more united, and, therefore, more effective. It is beyond the scope of this talk to detail plans of procedure, but whatever plans are made and followed, whatever further changes are necessary in our laws, active public interest will be necessary for the support of our enforcement staff. If the citizens of this State, are sufficiently aroused to the importance to all of us of this condition, and let our appointed and elected officials know unmistakably of our interest, our wishes and our expectations, we will be taking sure steps toward the solution of the problem.

# PEDIATRIC PROBLEMS OF THE GENERAL PRACTITIONER*

HENRY E. UTTER, M.D.

The Author. *Henry E. Utter, M.D., of Providence. Member, Visiting Staff, Rhode Island Hospital.*

THE PROBLEMS of childhood which confront the physician are alike for both the man in general practice and the pediatrician. Subjects chosen for discussion tonight are those which lead to unhappiness and misunderstanding between physicians. These problems are simple but important. Children are taken from one doctor to another in the hope of finding a perfect solution of these matters. Persons take their children to another physician because of a lack of faith and to some extent intelligence. The layman too often believes that medicine is an exact science where as we realize that this is not true: he thinks a physician should be able to answer correctly all his questions relative to health and disease. Each physician may handle an individual problem in a different manner but the same result may be obtained.

### *I. Infant Feeding*

Our methods of infant feeding have changed materially in the past twenty-five years. Our mode of life with its greater stress upon the nervous system, the entrance of the woman into the affairs of the world with the resultant demand upon her for out of the home activities and above all the universal trend toward the hospitalization of all women for the delivery of their infants are the main factors which are responsible for the changes in the system of infant feeding.

Formerly when babies were born in the home nearly all mothers nursed their infants for a varying length of time. There was a more intimate relation between the mother and child from the start of the infants life. The mother who suffered the pain of labor perhaps was more appreciative of her infant because of the difficulties of her labor. Today the mother has a painless labor, is divorced from her baby during its stay in the hospital and more than half of our women never nurse their babies. This raises the problem of artificial feeding from the first day of life. Many trial formulae are given and with each failure during the early weeks of adjustment to cow's milk the advice of a different physician is sought. This leads, even though unavoidable, to unhappiness among physicians.

If the baby is breast fed many of these early matters of maladjustment to cow's milk are eliminated. There are still physicians who believe that breast feeding is the correct and easy way to feed a baby and that bottle feeding is the wrong and hard way. There are obstetricians who believe that breast feeding hasten the convalescence of the mother and fosters a more stabile nervous system in the post partum months. There are surgeons who state that cancer of the breast in later life is more common in women who do not nurse their infants than in those who do even for only a short period. These surgeons believe that the high cholesterol content of the first milk which is left in the breast with dilatation of the ducts of the mamary gland is detrimental to the future health of the breast. On the other hand there are men interested in the cancer problem, from experiments on mice, who think that should there be a definite history of cancer in the family, that the mother should not nurse. This is a whole matter for discussion in itself.

In your care of feeding cases a friendly criticism of the man in general practice is that too much time is devoted to the matter of formulae and calories rather than to the general life of the infant. The questions relative to the schedule of feeding, the hours to be spent out of doors, the amount of fresh air to be allowed the baby at night, the clothing of the baby, the number of blankets to be placed over the infant at night and above all emphasis upon a minimum handling of the baby together with a psychological study of the mother herself are of infinitely greater importance than are the ingredients of the formula, which however, must not be neglected.

There is probably no type of case which comes more often before the pediatrician, with resultant ill feeling on the part of the general practitioner, than does the problem of infant feeding. What then should be the attitude of the pediatrician in the case of infant feeding which has been under the care of another physician? If the infant has been referred by a physician for advice there should be no question as to the disposal of the case. Advice should be given and the baby returned to the original physician.

* Presented before the Bristol County Medical Association, November 1946.

In all cases which have been under the care of other physicians the pediatrician should make an attempt to continue the formula given by the other physician or with as little modification as possible. An immediate change of formula destroys the faith of the mother in the first physician, a fact little appreciated by most physicians. To the mother a change of a radical nature of the ingredients of a formula indicates that the one she was using was wrongly constituted: often not the case. A change in the formula can be made later over the telephone if necessary without embarrassing another physician. Often the bill rendered by the first physician is never paid because the second doctor changed the formula, thereby convincing the parent that the first physician had made an error in the formula prescribed.

Another problem in ethics is presented to the pediatrician by the infant which he is called to see at a lying in hospital by the obstetrician. The mother may have been referred to the obstetrician for delivery by a physician who had no access to a lying in hospital service. The family doctor possibly expected to continue with the baby and is often dismayed to find that the infant has been referred to a pediatrician for feeding regulation. The pediatrician is ignorant of the situation and continues the care of the infant. At the end of the period of feeding supervision the pediatrician at least in the case of infants who come from a distant point should inquire the name of the home doctor and refer the child to him for future care.

Relative to the host of infants who have been under the previous care of one or more physicians the pediatrician has no alternative other than to accept the case. He must accept the prerogative of the mother in the choice of a physician. Many of these infants when the feeding difficulties have been rectified could be referred to the family doctor.

One of the most disagreeable matters for the pediatrician is to decide whether he should take care of a second baby which arrives two or three years after he has seen the first born in consultation. Perhaps the second baby was delivered by a different man and yet when the original doctor learns that the pediatrician is taking care of the second baby he resents the lack of faith which the family has in him. This situation is unavoidable for should the pediatrician attempt to refer the mother back to the original doctor she will usually flatly refuse. Later, however, when the baby has improved and her apprehension has been allayed the family doctor might assume the care of the child.

### *II. The Annual Physical Examination*

At first thought you might ask—why mention such a protean subject? The lay press, the Federal Child Health Bureau, insurance companies and our medical journals advise this and it has become in the minds of many mothers a necessary annual function. Many children brought to the pediatrician have during the year been under the care of the family doctor. Why then should the mother take the child to the pediatrician? Does she believe that he will give a more thorough examination? If this is the reason, it should not be true.

The annual examination should consist of an examination of all organs. The child should be weighed and measured. Especial attention should be given the teeth and feet of growing children. The urine should be tested. A patch tuberculin test should be done; if positive an X-ray of the chest should be taken. The physician should acquaint himself with the quality of the family milk supply. He should inquire about the diet and make sure that all food elements are being given. All children should have vitamin D preferably in the form of pure cod liver oil. All other vitamins should be provided in the food.

The parent should be discouraged in the use of multiple vitamins, important to the pharmaceutical house perchance but having no place in the diet of the properly fed child. The parent who gives her child multiple vitamins tries to relieve her conscience for not providing the proper food. If an added vitiman is indicated use that vitamin and not a shot gun mixture of vitamins.

If the general practitioner will give a full physical examination to each child coming to him for this purpose rather than passing over the matter lightly the pediatrician will not be so frequently consulted for this reason.

### *III. The Tonsil Question*

This is primarily although not entirely a problem of childhood. Some years ago tonsillectomy was considered an element of preventive medicine but ideas have changed in this matter. The tonsil is not a vestigial organ in the process of evolution. Tonsil tissue is a part of the lymphatic or if you will the filter system of the body. The tonsil of the child is digesting the bacteria which gain access to the throat. In the fall of the year when respiratory disease becomes more prevalent routine examination of the throat will often reveal large, red and swollen tonsils when the child has no outward manifestation of illness. Not infrequently when a child loses its appetite with no other symptoms we find a swollen, inflammed tonsil. Only when a child comes in contact with an overwhelming number of bacteria does the child become ill. Is this illness any more than a manifestation on the part of the

*continued on next page*

body calling upon other defensive measures such as a temperature and an increase in the leucocytes?

One attack or more of simple uncomplicated tonsillitis do not form a positive indication for tonsillectomy if the tonsil quickly returns to normal. The physician who condemns the tonsil to operation during an acute attack opens himself to criticism by the family. The parent of such a child will probably take the child to the nose and throat specialist or the pediatrician who finds a small innocent tonsil which has returned to normal. The physician should see the child after the attack and reserve his decision about the removal until then. The physician who hears a cardiac murmur while the child is ill and reveals his discovery to the parent likewise opens himself to criticism of the family. The persistence of the murmur after the subsidence of the fever should prompt the physician to tell the parent. Many of these children fall into the hands of the pediatrician for confirmation and he finds no murmur after the attack of fever.

Tonsillectomy should be postponed until the child has passed the age of four if possible and the later the operative date the more permanent the result. 1. Removal of the tonsil of young children is nearly always followed by lymphoid hyperplasia in the pharynx and tonsillar fossae. 2. This lymphoid tissue becomes easily infected and is responsible in a large measure for the intractable night coughs which are so disturbing to parents. 3. Early tonsillectomy in the allergic child is often followed by attacks of asthma, usually in the child precipitated by an acute upper respiratory infection. 4. Children whose tonsils have been removed are more susceptible to sinusitis and bronchitis. The tonsil having been removed the mucous membrane of the sinuses and the bronchi become much more vulnerable to attack. 5. Deafness is more common in the child whose adenoid has been removed. This may be due to the fact that new lymphoid tissue encroaches upon the orifice of the Eustachian tube. Occasionally too vigorous use of the adenoid curette may destroy the mucous membrane at the tubal orifice.

What then are the positive indications for the removal of the tonsils? 1. Rheumatic fever or one of its manifestations. I have always believed and have had no occasion to change my mind that the virus or whatever the infecting agent may be always enters the body through the tonsil or lymphoid tissue which appears after tonsillectomy. 2. Repeated attacks of tonsillitis complicated by cervical adenitis or otitis and when the tonsil does not return to normal after an attack. 3. Deafness as the result of a chronically inflammed adenoid. 4. Tuberculous cervical adenitis. 5. Given a child who is below par and in whom there is a negative physical examination, urine blood count and tuberculin test; tonsillectomy in such a child will usually be followed by a return to normal health.

### *IV. Respiratory Disease*

The treatment of respiratory disease in childhood has undergone radical changes with the advent of the sulfa drugs and penicillin. Complications have been greatly reduced and many lives are being saved which might have been sacrificed before these drugs were available. Next to the feeding case the child with recurrent or chronic respiratory disease is more commonly taken from one doctor to another. A cough, particularly a continuous cough or the night cough which disturbs the sleep of the whole family is an ominous sign in the minds of the layman. Cough mixtures so commonly prescribed as the only treatment are of little value. The site of the infection must be determined and treated accordingly.

Studies in allergy have produced much interesting information pertinent to respiratory disease. The allergic child is much more susceptible to infection than the non-allergic child. We are convinced that the child or adult who is susceptible to respiratory disease is also a subject of allergy. Children who have chronic sinusitis are for the most part allergic individuals. Thus in a large group of children allergy tests must be done to determine the underlying factors in the production of bronchitis other than a simple acute attack and sinus infections. Scratch tests are simple and in the majority of cases only the more common allergens need be used. If we will devote our attention to the treatment of the site of infection, we will have a less frequent change of physicians.

What of the use of the sulfa drugs in acute respiratory disease? There still exists in the mind of many physicians a fear of the sulfa drugs. This fear is based on the fact that we are taught in using these drugs to raise the blood level to 10 m.g. per cent. This means that we prescribe the maximum dose when often this is not necessary. If we would use the sulfonamides in proportion to the severity of the symptoms, we would have better results and few reactions. Children tolerate the drugs better than do adults. If we start the drugs at the onset of an acute infection we will have a minimum of complications. We may encounter a simple catarrhal otitis or cervical adenitis but seldom will either go on to suppuration as in the presulfa days. In severe respiratory disease both the sulfa drugs and penicillin should be prescribed conjointly.

### *V. Loss of Appetite in Normal Children*

This is a common symptom because of which parents change their physician. This is a common problem for the pediatrician. It is a problem of the pre-school years and later. The child refuses to

*continued on page 109*

# PODOPHYLLIN IN THE TREATMENT OF CUTANEOUS VEGETATIONS

F. RONCHESE, M.D.

The Author. *Francesco Ronchese, M.D., of Providence. Dermatologist-in-Chief, Rhode Island Hospital; Instructor in Dermatology, Boston University.*

PODOPHYLLIN, no more in official use as a cathartic, has been returned to service in the therapy of acuminated warts (condylomata acuminata, soft warts), the cock-comb-like, cauliflower-like vegetations growing in the warmth and moisture of genital and anal areas. Acuminated warts are often called, improperly, venereal warts or venereal vegetations, because they are not necessarily related to a venereal infection.

Sometimes the areas involved are so extensive and the warts so voluminous as to offer a serious therapeutic problem.

Apparently, the same penetrating-irritating power of podophyllin for the intestinal mucous membranes causing catharsis, penetrates and shrinks the polipoid vegetations growing on the mucous membranes of the penis, vulva and anus. It seems to be completely ineffective on the hard (vulgar) warts of various types developing on the skin.

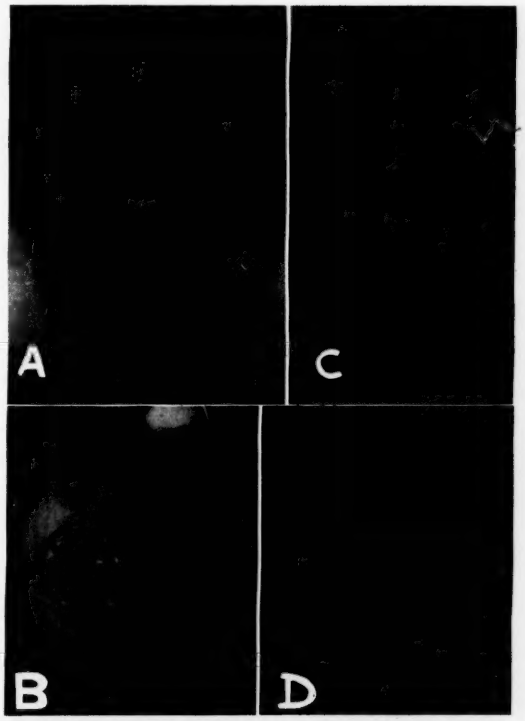
I have experienced several times in cases of acuminated warts of the glans penis and foreskin, that the efficacy of podophyllin stops abruptly at the line of transition between the semi-membrane and the skin proper. When the acuminated wart becomes a hard (vulgar) wart no more penetration of podophyllin takes place.

Kaplan[1] was the first to use the remedy as a mixture of 25 per cent podophyllin in mineral oil and others[2] confirmed the results and contributed to the subject with experimental studies.

In my experience the method is very effective and saves a great deal of time and distress, specially in the female, avoiding hospitalization, anaesthesia and surgical procedures.

The method is not as good in the male because of the possible balanitis. If the foreskin is present and many warts are to be destroyed, circumcision is preferable.

While spontaneous overnight involution of vulgar warts is a matter of common knowledge, I have found in the literature only one case of spontaneous disappearance of acuminated warts. Gaté and Coste[3] tell of a 4 months pregnant woman with vulvar vegetation so exhuberant that she was prepared for surgical excision. Because of a stomach ailment she was given by mouth a mixture of bismuth, magnesium, sodium bicarbonate, calcium, kaolin. Four days after, the vegetations became smaller and in 29 days they had disappeared completely.




Acuminated condylomata of vulva (A), male urinary meatus (B), anus (C), suitable for podophyllin therapy. Acuminated condylomata of foreskin (D) too hard for podophyllin therapy.

Would podophyllin act through the same inexplicable channels called suggestion?

Object of this paper is the report of the following case:

"A middle age man, a polisher in an optical factory, had for several weeks a patch of sycosis vulgaris on his chin. This condition showed the usual resistance to various forms of therapy (penicillin, furacin, tyrothricin, quinolor,

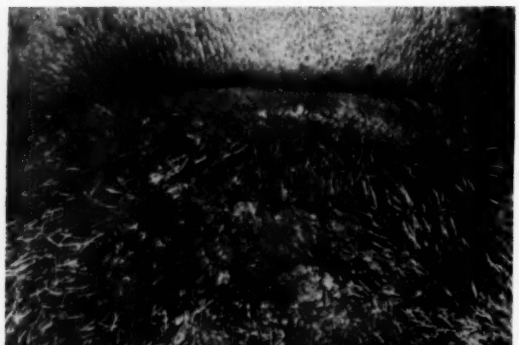
*continued on next page*

roentgen rays, etc.) One day, after removing a heavy coat of dried up exudate holding on a frame work of heavy whiskers, the area appeared papillomatous, and bleeding freely from long digitated papillae, having the clinical appearance of the acuminated condylomata seen in the male or female genitalia (see illustration). Evidently, the solid shelter furnished by the heavy whiskers and the dried up exudate duplicated the situation promoting the formation of acuminated condylomata about the genitalia, namely, a warm, enclosed area soaked in a muco-purulent exudate.

After clipping a few vegetations for pathological examination, I applied, as I have done for acuminated condylomata, a thick layer of a 25 per cent mixture of podophyllin (Resin Podophyllum, N.F.) in a water soluble base (Hydrosorb). The patient was instructed to keep the dressing on for 8 hours and then carefully cleanse the area with mineral oil and apply boric acid ointment.

The local reaction was severe. The man had to stay home for one week with wet dressings and sedatives, but at the end of the week his chin was perfectly clear of vegetations and of his sycosis. There were no signs of recurrence after several months."

Garnier, discussing Touraine communication[4] recalled the excellent results obtained in the past with the use of sabina powder in acuminated warts. Perhaps the old formula (Sabina U.S.P. powder-alum powder-copper sulphate powder — equal parts) could be also revived, and eventually studied as has been colchicine[2].



Acuminated condylomata-like vegetations on a man's chin following a long-standing sycosis vulgaris.


### *Summary*

A case is reported of cutaneous vegetations occurring on a man's chin after a long standing sycosis barbae.

The vegetations had the clinical and pathological features of acuminated condylomata. Genital contamination could be reasonably excluded.

As various therapeutic methods failed, a 25 per cent podophyllin ointment was used with success.


### References


1 Kaplan, I. W., Condylomata Acuminata, New Orleans Med. and Surg. 94:388, 1942.

2 Culp, O. S., Magid, M.A. and Kaplan I. W., Podophyllin Treatment of Condylomata Acuminata, J. of Urology, 51:655, 1944—Macgregor, J. V., Treatment of Soft Warts with Podophyllin, Br. M. J. 1:593, 1945.—Gersh, I., Condylomata Acuminata of the Male External Genitalia: An Effective Method of Surgical Treatment, Urol. and Cut. Rev. 49:432, 1945—King, L. S. and Sullivan, M., The Similarity of the Effect of Podophyllin and Colchicine and Their Use in the Treatment of Condylomata Acuminata, Science, 104:244, 1946.—Anderson, C. S., Treatment of Condyloma Acuminatum with Resin of Podophyllum, Arch. of Derm. and Syph. 54:66, 1946.—Cohen, E. L., The Treatment of Penile Warts (Condylomata Acuminata) with Podophyllin, Practitioner, 156:133, Feb. 1946.

3 Gaté, J. and Coste, J., Végétations vulvaires au quatrième mois d'une grossesse disparues spontanément après un traitement intercurrent par une préparation saline, Bull. Soc. Française de Derm. et Syph., 6:164, March 1946.

4 Touraine, A., Traitement des végétations vénériennes par la podophylline, Bull. Soc. Française de Derm. et Syph., 5:193, July-August 1945.


*170 Waterman Street, Providence 6, R. I.*

# OTOSCLEROSIS, PROGRESSIVE DEAFNESS AND CORRELATED PROBLEMS*

## What Has Research Discovered and What Does the Future Promise?

EDMUND PRINCE FOWLER, M.D.

The Author. *Edmund Prince Fowler, M.D., of New York City. President, New York League for the Hard of Hearing.*

FROM THE SUBJECT assigned to me, it is obvious that you did not expect much that is new, and therefore would not be disappointed if I were to repeat the usual statement that, whereas nothing has been discovered regarding the cause of otosclerosis nor regarding its cure, we must still continue our research.

To say this would lead to false implications. We do know a great deal about otosclerosis and about the changes in the tissues of the ear which we call the lesion of otosclerosis. We have discovered that these changes occur in every year of life, and even before birth, although they seldom cause deafness early in life.

In spite of the fact that a knowledge of the morphology, that is, the microscopic appearance of otosclerotic changes, has not given us any clue as to cause, it is nevertheless fundamental, and aids in setting up theories. If we did not known what changes take place we would be unable to recognize the lesion when we see it. The appearance of the otosclerosis growth is now so well understood that it can be differentiated from other diseases of the bone with which it was formerly confused.

Whereas our knowledge in morphology and pathology is now complete, the factors concerned with the predisposing and exciting causes of otosclerosis are still nebulus. The only sure factor is heredity, but heredity, alone, is not the cause of otosclerosis. As for symptoms, probably the majority of my audience know them better than the doctors.

### *Central Bureau of Research*

Only a few of the important discoveries can be mentioned here. To insure continuity in research a worker must have security and encouragement for long time effort, and this can come only through continued financial and inspirational support. Such has been the basic policy of the Central Bureau of Research of the American Otological Society. For twenty years this Bureau has aided many men and many institutions in their studies to find out how the ear works in health and in disease. When published, a copy of their report, including the latest developments in otosclerosis and correlated fields, will be sent to each Chapter of the *American Hearing Society.*

### *Diagnosis*

Early diagnosis is a prerequisite to satisfactory treatment. Early diagnosis implies a perfection of tests and testing. It depends largely upon hearing tests and careful otological examination, at the very latest when the child enters school, and earlier in otosclerotic families. Slowly, but surely, differential diagnostic criteria are being perfected. We have discovered tests for surely differentiating nerve from obstructive deafness. But there are many types of obstructive deafness.

The greatest difficulty has been to differentiate deafness due to bony ankylosis from deafness caused by fibrous adhesions. Many cases of fibrous obstruction have been mistaken for otosclerosis. If we cannot make a sure diagnosis in a high percentage of cases we cannot obtain reliable statistics on the effects of treatment. To my mind these facts clarify the picture and encourage factual thinking.

### *Incidence*

A large number of you have been told that you have otosclerosis; a very large number of people have otosclerosis and do not know it. In fact, nobody knows it until it causes deafness, and a diagnosis is made.

In the United States it is estimated that there are between 10,000,000 and 12,000,000 people with otosclerosis. Of these, between 1,000,000 and 1,200,000 have an ankylosis of the stapes sufficient to cause deafness. The immensity of the problem is apparent.

The incidence of otosclerosis varies between races, and with age and sex. In the white race it is encountered about twice as often in women as in men. In those under twenty-one years of age this sex ratio is higher. The activity of otosclerosis, in other words, its growth and extension, and therefore its increasing threat to hearing, varies greatly

*continued on next page*

* Presented at the Eastern Zone Conference of the American Hearing Society, at Providence, R. I., October 24-26, 1946.

with the age of the individual. Only 4 per cent of those over five years of age, autopsied by Stacy Guild, showed otosclerosis, but if the Guild's survey had contained the same number of females as males, the figure would have been much higher.

In the Negro the percentage of occurrence is different; almost unbelievably different, because the incident figure for the Negro is only about 1 per cent. The question naturally arises:

*Why does the white race have otosclerosis so much more frequently than the Negro?*

We welcome suggestions on this subject. Between the two races no significant differences in the blood or the tissues have been found which cannot be explained by variations in environment, particularly climate and diet. However, it may be worth noting that the Negro mother regularly nurses her baby, the white mother not half as regularly. There are certain differences in the chemical content of the milk of the two races. There are, of course, several marked differences between human milk and cow's milk, and, for the human infant, all are in favor of mother's milk.

All of these factors may, and often do, influence the development and aging of the bony tissues and the functioning of the endocrine system; and more so at certain ages. These facts appear to be important discoveries. There are many others.

### *Ankylosis*

The mere presence of otosclerosis is not the important thing. The important thing is the activity of the lesion and the rate and extent of its growth. Unless it reaches a size sufficient to involve the membrane between the stapes and the oval window margin, otosclerosis is not disabling; nor does it cause deafness. It is the ankylosis that causes the deafness, and otoclerosis usually does not cause ankylosis unless it is active for a long time.

It is encouraging to have discovered that in people found at autopsy to have had otosclerosis, only one-half showed active lesions. In other words, in only half of the people who had otosclerosis over a period of years prior to their death was it progressing at the time of death. To those about to die, this is of no great importance. But to those who expect to live for many years it is a comforting thought. In only 10 per cent of those with otosclerosis was there any deafness which could be attributed to otosclerosis. Coincidental middle ear or nerve conditions, having little, if anything, to do with otosclerosis, accounted for a history of deafness in 90 per cent of the ears harboring otosclerosis.

Still more encouraging is the fact that in those autopsied by Stacy Guild, after the age of fifty, only one in three showed active lesions. That is, only one out of three persons over fifty years of age, having otosclerosis, was at the time of his death threatened by any deafness, or by any increasing deafness resulting from otosclerosis.

Other causes of deafness, of course, begin to operate more frequently in people over fifty, so that if it isn't one thing, it is another. However, before fifty years of age we can, in fairness, expect only a 50-50 chance in most things; after fifty, a 2-1 chance is perhaps more than we should expect.

Again, I want to stress the importance of early diagnosis. It is true that the hearing loss in otosclerosis tends to progress slowly to about a 50 per cent loss for speech, and thereafter to become stabilized unless other troubles supervene. Because the otologist seldom sees a patient suffering from otosclerosis before severe damage has been done, he has no opportunity to try out certain remedies which would seem indicated to arrest the disease and the accompanying progressive deafness.

### *Operation*

Although it seems inconceivable that the bony changes which cause deafness in otosclerosis can be removed, it is conceivable that they may be stopped. Certainly in many instances they can not only be stopped, but, in part, may be circumvented by operation. I say "circumvented," not "removed," because the fistula operation, in spite of many assertions to the contrary, gives no evidence of having any curative effect upon the otosclerosis, nor does it prevent its extension. Moreover, it cannot restore the hearing. It can, and often does improve the hearing, and in many instances to a considerable degree. The operation is still experimental, but in proper hands, in favorable cases, shows promise of giving relief for variable lengths of time.

We have discovered some of the reasons why the operation so often fails, and this knowledge has been applied to operative technique. Much progress has been made, but even now, we cannot in truth assure any patient, no matter how favorable a subject, that his hearing will be restored, or improved to any given degree. He must take his chance, which, even if the patient belongs in the favorable class, is only 50-50 for a result satisfactory enough to warrant the expense and risks involved. To some people, even a slight improvement appears to be satisfactory, but the operation is seldom warranted if we obtain only a slight improvement in hearing. To much is involved for too little.

I am aware that some statistics show a remarkably high percentage of successes in what are called favorable cases. The difficulty is that the surgeon is unable often to determine beforehand which is, and which is not, a favorable case. If he chooses the favorable case after the operation, he is picking the winner after the race is won. I say this to cau-

tion you against accepting statistics without examining the methods of their compilation, without knowing their reliability, and without realizing the many variables underlying all surgical procedure.

Much time and effort have been devoted to discovering a method of preventing the closing of a fistula by the regeneration of bone following fenestration operations on the monkey. J. B. Lindsay, at the University of Chicago, found that the closing of the fistula arose from regeneration of the periosteal and endoesteal (inner and outer) layers of the capsule. Also, that the endosteum cannot be left without leaving some bone flakes, thus forming a network for bony degeneration; and that complete removal of the bony fragments always resulted in the removal of the endosteum. Many kinds of fistula covers or "stoppers" were used in many locations, and with many variations in technique. It was found difficult to remove the bone fragments completely without injuring the membraneous canal and the endosteum beyond the margin of the fistula. No certain procedure was found to permanently maintain patency of the operative fistula.

### *Hearing Aids*

During the past twenty years there has been a great improvement in hearing aids, so that those with even severe deafness from otosclerosis can be made to hear quite well at conversational distances. If properly made and adjusted, a hearing aid is able to increase the loudness of any sound more than the fistula operation.

A new phenomenon in the physiology of hearing was discovered. I call it the "recruitment phenomenon," or "recruitment of loudness phenomenon." Recruitment is present in all cases of nerve deafness; it is never caused by obstructive deafness. Those with nerve deafness often have difficulty in using hearing aids because there is an abnormal increase in the loudness of sounds when their intensity is increased. Some day, I predict, we can hold this recruitment effect down to comfortable levels. What is needed is an acoustic shock absorber which will permit a sound to reach the ear up to a given desired intensity, and no further. Hearing aid manufacturers, please take notice.

### *Contributions to Research*

Research has contributed much to our knowledge of how the ear works. For many years, Doctors Wilson, Anson and Bast have been studying the developmental changes and mechanics of the ear in health and disease. They have found in the human ear an interesting connective tissue cleft which extends through the bony otic capsule just in front of the oval window, and this so-called fissula (not fistula) sometimes is involved in developmental defects affecting the cartilage and bone surrounding it.

The region where this fissula exists is the place of predilection of otosclerotic foci. There is here, therefore, an embryological basis for abnormal tissue which may be implicated in the changes causing otosclerosis. Many intra labyrinthine structures were carefully examined at various stages of their life cycle, and several new structures described.

The size of the stapes was found to vary considerably at all ages, and sometimes as much as one and one-half times. Its structure also varies with advancing age. The stapes grows so rapidly that it reaches full adult size by the time the fetus has completed the first half of its intra uterine life. Other human bones generally do not obtain full size until the individual is eighteen to twenty years of age. From the fifth to the seventh month of intra uterine life the stapes also attains adult form and consistency. So you see, this, the tiniest bone in the body, like the bone immediately surrounding it, is fully grown and therefore quite old at birth.

### *Experiments with Animals*

In the brilliant experimentation at McGill University the hearing of animals was studied by the method of the conditioned reflex. It was found that the human being could not hear the higher pitches as well as many lower animals. The dog proved to have better pitch discrimination than the cat, but more difficulty and diffidence than the cat in learning to raise the lid of the food bin. The dog was more easily distracted than the cat. In pitch discrimination, man is superior to both. (This may be the reason why man, in spite of his post war tribulations, is still in there pitching!)

Dworkins' animals with partial deafness due to localized lesions in the cochlea were sent to Davis and Lurie at Harvard Medical School for correlative studies with electrical stimuli. It was substantiated that the inner ear acts as a transformer of acoustic into electrical energy, and this microphonic action was used as a tool for analyzing the effects of contractions of the inner ear muscles upon the transmission of sound.

No experimentor has been able with certainty to produce otosclerosis in animals, although lesions similar to otosclerosis have been produced by various operative and chemical procedures. Injuries, acoustic shocks, and temporary fatigue produced by intense sounds, have received especial attention. A most significant contribution to research has been the isolation and analysis of the electrical activity of single nerve fibers in the auditory nerve. For a discussion of these I refer you to the progress report of the Central Bureau of Research.

*continued on next page*

The animal hearing laboratory at the University of Illinois came into existence by a grant from the Central Bureau of Research. Here, and at the University of Rochester, Culler trained (conditioned) animals to respond by simple movements to any audible tone to which they reacted as long as they heard it; that is, as long as the tone was not below the threshold of hearing. When the sound was inaudible they no longer reacted. In this way it was possible to have the animal, both before and after the different operative procedures, signal when he heard the test sound.

With electrical methods the problems could be attacked in several ways. It was concluded that:

(1) Each frequency has its own focus of response within the cochlea, this point being revealed by the electric potential therein generated.

(2) The location of this focal point can be fixed within standard error of 5 per cent.

Extensive experiments with electronic potentials from the cochlea and from the auditory nerve and tracts show that these potentials differ. These from the cochlea arise in the ear itself as they can be obtained even after the nerve has been cut, and the endorgan of hearing destroyed; and sometimes, even after death. Each discovery leads us one step further along the path of knowledge.

The relative value of the auditory tracts to the brain were studied. It was found among other things that there appeared to be no appreciable difference in the hearing after removal of the right or the left hemicortex.

The effects from removing various other portions of the brain and cochlea were studied. All of these experiments showed a high safety factor in the hearing system; so high, in fact, that it compares very favorably with that found in engineering practice. These experiments brought out many facts fundamental for an understanding of the healthy and diseased mechanism of the ear.

It has been claimed by some that X-raying of the petuitary body in the skull improves the hearing. Culler's experiments show that this may be true in many instances, but the effect is always transient. It should be noted, in passing, that repeated X-raying of the head of a human being may be dangerous.

Culler mapped the distribution of the auditory nerve in the central ganglia and in the auditory cortex, and its frequency distribution in the cortex of the cat. There seems now to be little doubt that frequency localization begins in the cochlea, and persists throughout the auditory tracts to the cortex. Culler also examined the hearing of dogs before and after taking certain selective nerve poisons.

These researches provide a lead for defining the mechanism by which auditory nerve impulses are routed through the cortex of the brain after they reach the temporal projection area.

It was held in the past that partial section of the auditory nerve had no appreciable effect upon the hearing, but it has been found that even a slight destruction causes some impairment. Extensive cutting of the nerve causes a large impairment of hearing. A differential character to the losses is detailed in the progress report to which I have referred.

Studies on the higher acoustic mechanism in the cat were carried out by training these animals to react whenever the intensity of a testing tone was suddenly increased. The minimum detectable increase was determined. The usual test determines when a tone is barely audible.

After complete removal of the auditory cortex on both sides of the head, these animals, when retrained, showed post-operative (minimum differential) thresholds the same as before operation. In other words, in the absence of the auditory cortex on both sides, subcortical centers were just as efficient in differentiating the loudness of two tones as was the cortex area itself. Moreover, the discrimination habit remained intact, and differential thresholds were not significantly altered after destruction of the inferior or superior colliculi on both sides.

Many similar experiments were carried out. Studies on the peripheral mechanism of hearing, and especially on the nature of masking, revealed important and hitherto unknown facts.

### *Other Studies*

Thousands of temporal bones have been collected, serially sectioned, studied, and carefully filed for future use. Models of both the bony and membraneous labyrinths have been made. Systematic examination of all patients have been made by one of us (Fowler) and recorded under six diagnostic and several age groupings. Careful otological examinations with blood chemistry, X-rays, endocrine and metabolism tests, have revealed some interesting facts. It is now believed that the most promising approach to the problem of otosclerosis and other forms of porgressive deafness lies in clinical research.

Changes in the hearing at puberty, during menstruation, and pregnancy; the puerperium, lactation, and the menopause were studied. There is apparently no difference in changes in hearing during menstruation in those with otosclerosis and those with deafness caused by other obstructive lesions. The hearing always returns eventually to its former level.

Studies, also, were made of people with brittle bones, blue scleras and otosclerosis. Means have been devised for measuring the loudness of tinnitus

and detecting its place of origin and its implications in diagnosis.

### *Call for Twins*

Studies in identical twins have revealed many interesting identical and differing reactions to environment. In five pairs, one twin in each pair is being treated differently from the other. We need more identical twins. That is a strange call from a man, but I mean it. Please remember to send me more twins, especially twins with a family history of otosclerosis. Also wanted are triplets, quadruplets, and even quintuplets.

And here is my final word. Please, please send these children early, before crippling deafness appears. If you will do this not only for your twins, but for all of your children, the future promises much in the prevention and arrest of deafness.

---

## PEDIATRIC PROBLEMS OF THE GENERAL PRACTITIONER

*continued from page 102*

eat without the coercion of all members of the family. At each meal there appears the enactment of a drama with the child acting the part of the hero.

The main cause of this condition lies in the fact that during the first year of life the average child eats more food than during the second and third years of life. This is due to demand on the part of the body during the first year of rapid growth. The average mother thinks the child should eat more with advancing age. This starts the forcing procedure and then follows the pattern of feeding which seems quite normal to the child. Teething or an illness in the second year may be responsible for the anourexia because the child is forced during an illness and the pattern persists after the tooth has erupted or the illness has passed.

Tonics have little effect. Leaving the child to dawdle over its food does not change the type of eating habit. The parent is never satisfied to be told that the child will eat when it is hungry. Limiting the amount of time spent at the table does not suffice. The secret in brief, consists in underfeeding the child. Small quantities of definite types of food should be prescribed. The child is the only one who knows the extent of its own appetite. The amounts of food should be increased only when the child requests an increase. The child must be taught to ask for food and only when this has been achieved will the eating behaviour pattern be changed.

In conclusion the most common problems of childhood which disturb the physician-patient relationship have been discussed. The relation between the general practitioner and the pediatrician should be a pleasant one and mutual helpfulness can result. If we as physicians would but appreciate the complete lack of ethics among the laiety we could better understand each other. Doctors are often misquoted in their remarks concerning each other. Often derogatory remarks about a physician are the products of a mind of an individual who enjoys the unhappiness which is produced by such language. Physicians would be much more contented if they omitted the criticisms so often heard, of their fellow practitioners.

---

# The RHODE ISLAND MEDICAL JOURNAL

*Owned and Published Monthly by the Rhode Island Medical Society,*
*106 Francis Street, Providence, Rhode Island*




## OUR SURGICAL PLAN

*An Historical Report of Its Development*

AT THE CALL of the president of the Society a special meeting of the House of Delegates was held on Sunday, December 17, 1944, to hear the report of the Committee on Medical Economics regarding a possible plan for prepayment of surgical expenses.

The report of the Committee was accepted, and its proposal that a committee of 11 members be formed to study the formation of such a program was adopted. Six of the members were to be members of the Rhode Island Medical Society elected by the House of Delegates for staggered terms, and these elected members were to elect five non-medical members to serve with them.

Prior to the first meeting of the entire group of eleven men named to serve on the committee, it was suggested by Mr. George Davis, one of the five citizens elected to serve on this volunteer committee, that enabling legislation should be introduced in the Rhode Island General Assembly before the 42d day. On March 10 the executive secretary furnished Mr. Davis with copies of the enabling acts for the incorporation of non-profit medical service corporations already enacted in other states. Mr. Davis drafted legislation over that weekend, and it was introduced in the House of Representatives of the Rhode Island General Assembly on Tuesday, March 13, 1945, and subsequently referred to the Committee on Corporations.

The first meeting of the entire committee was held on Wednesday, April 11, 1945. The non-medical members elected to the committee were Mr. Roderick Pirnie, Mr. George C. Davis, Mr. Ralph Kenyon, Mr. Charles Baker, and Mr. Harold Amrhein. At this meeting Mr. Farrell discussed the enabling legislation that had been introduced and particularly pointed out that Section 9 had been reviewed by the Committee on Public Laws of the Rhode Island Medical Society which had recommended that this section be amended to provide that the Society might authorize any non-profit hospital service corporation to amend its articles to adopt the provisions of this act (the surgical plan act) *in whole or in part.* As the act was originally written it made it mandatory to transfer to the Blue Cross Corporation *all* authority. The committee moved to approve of this amendment.

However, in spite of the opinion of the Society through its Committee on Public Laws and the official notification of its action to the Assembly committee and to the Governor and other authorities in the State government, the original legislation was passed as written.

At no time did any official of the Rhode Island Medical Society certify to any member of the Assembly or any other citizens that osteopathic physicians would be eligible for participation under the program.

* * * * *

A sub-committee of the special surgical study committee was appointed to study the question of relations with the Blue Cross Organization. This sub-committee comprised Mr. Roderick Pirnie, Mr. George C. Davis, Mr. Charles H. Baker. It made its report on October 24, 1945, in which it reviewed the actions of the previous meetings of the entire committee and made definite recommendations. A significant viewpoint was voiced in the following conclusions of the sub-committee report.

*"After a most thorough consideration of all aspects of the matter it is our recommendation that the Rhode Island plan be patterned upon that of Delaware, which follows in general the pattern of commercial insurance with which the public is already familiar, but which has the added advantage of the endorsement and support of the medical profession. In this way, if the Blue Cross can be persuaded to undertake the project, a practical operating arrangement can be achieved so that voluntary medical protection can be made available to the public of Rhode Island, both for their benefit and also as a defense to the various compulsory programs. Under such a plan service would be rendered upon a fee schedule, payable either directly to the attending physician or to the patient as seemed desirable upon further study.*

*"While it would be of the greatest importance that a substantial majority of the profession give their wholehearted support to the plan, it should not be necessary that every physician be a member in order to provide service to its subscribers. Free choice of physician and patient would be retained. Financial stability would be insured if a substantial majority of the members of the profession in Rhode Island were to become members and, as such, undertake to provide the necessary services regardless of the financial status of the corporation. The experience of other plans makes it highly improbable that there would ever be need to fall back upon this protection, but if it exists the necessity is avoided of raising substantial funds to guarantee performance.*

*"Since indemnity rather than service would be the basis of the plan, there is no more likelihood that there would be any conflict of interests between the members of the profession, the adminisrative group and the patients than there is now with commercial insurance companies. However, in order to assure the member physicians that the rights would be protected, an impartial board of arbitration should be provided with full authority to settle any disputes."*

At a meeting of the Surgical Insurance Study Committee on October 24, the sub-committee report, quoted in part above, was accepted and the committee moved that the recommendations be submitted to the Rhode Island Medical Society.

* * * * *

A special meeting of the House of Delegates was held on November 15, 1945 and the House voted unanimously as desiring a voluntary medical care program operated on a prepayment basis.

The House also voted to go on record as favoring a voluntary medical program which would be related to the Hospital Service Corporation with each service having a separate corporation and a separate board of directors, but a single executive director with one administrative staff. The motion was seconded and adopted.

A motion was made that the medical members of the surgical committee be asked to confer with the Hospital Service Corporation relative to cooperation with the Medical Society in the development of a surgical insurance program. This motion was adopted.

* * * * *

### *Special Meeting of the House of Delegates December 30, 1945*

A special meeting of the House of Delegates was held on December 30 to discuss the question of Blue Cross participation in the medical-surgical plan of Rhode Island. At that meeting of the House Dr. Pitts reported that he and members of his committee had met with members of the Blue Cross to discuss the proposal. He stated that the House had been called to consider whether it would accept the Blue Cross's ultimatum that it was not willing to work with two separate corporations, one for hospitalization and one for medical service. The Blue Cross objection was based on the fact that it would entail additional work for the director and, further, the Blue Cross Corporation was not anxious to take on the work, but was willing to cooperate as a public service.

After lengthy discussion of the situation the House adopted the following motion:

*"That the Rhode Island Medical Society accept the proposal of the Hospital Service Corporation*

**continued on next page**

*to cooperate with the Society in the sponsoring of a surgical-medical plan to be offered in Rhode Island in connection with the already existing hospital plan, provided that agreements are made that not less than 25 per cent of the Board of Directors of the Hospital Service Corporation will at all times be doctors of medicine appointed by the Rhode Island Medical Society for staggered terms, and further provided, that all medical and surgical fee schedules shall be adopted and amended only after approval by the House of Delegates of the Rhode Island Medical Society."*

* * * * *

***House of Delegates Meeting—January 31, 1946***

At the regular meeting of the House on January 31, 1946, Dr. Martin reported for the Committee relative to its meeting with the Blue Cross authorities. Highlights of his report, as well as the actions taken by the House of Delegates, were as follows:

He reported that the Committee favored a straight cash indemnity, but the arguments against this type of plan were strong. The program is to be one of community service to assist the lower income groups. But a cash indemnity only parallels existing private insurance plans. The Blue Cross membership has been built high by enrollment of the lower income groups, and to gain such groups for the surgical plan an income limit appears advisable. The Committee recommends, therefore, income limits of $2,500 for the individual, and $3,000 for the family.

---

Dr. Martin stated that the president and secretary of the Society would have to file an affidavit with the Secretary-of-State to authorize the Blue Cross to administer the surgical plan. He read as a suggested affidavit one that had been prepared by Mr. Davis, legal counsel for the Blue Cross, which read as follows:

*"RESOLVED: That the Rhode Island Medical Society does hereby give its consent that the Hospital Service Corporation of Rhode Island, a non-profit hospital service corporation organized pursuant to the provisions of Chapter 719 of the Public Laws of Rhode Island 1939, may amend its Articles of Association to adopt the provisions of Chapter 1598 of the Public Laws of Rhode Island 1945 entitled "An Act Providing for the Incororation of Non-profit Medical Service Corporations and Defining Their Powers," to the end that the said Hospital Service Corporation of Rhode Island may have and exercise all of the powers and be subject to all of the duties and responsibilities of a non-profit medical service corporation to the same extent as though it had been incorporated pursuant to said Chapter 1598."*

---

Dr. Mara moved that the Council of the Society submit a ballot with twelve nominees, and also provide suitable space for the writing in of counter-nominations, and that such a ballot be submitted to each member of the House of Delegates by mail for the election of representatives to serve on the Board of Directors of the Blue Cross with the six nominees receiving the highest votes to be declared elected; he further moved that the terms of office for the elected delegates shall be set by the House of Delegates at a future meeting. The motion was seconded and passed.

* * * * *

***Special Meeting of the House of Delegates February 24, 1946***

At a special meeting of the House of Delegates on February 24, 1946, the proposals for the surgical plan were discussed anew. Legal counsel for the Society reported as follows relative to the enabling act:

*It is our opinion, therefore, that the courts should, and probably would, limit the words "duly licensed" in the Enabling Act to those who have received a certificate to practice "medicine and surgery." This would exclude osteopaths and chiropractors who receive certificate to practice osteopathy or chiropractics.*

The conclusions advanced by the legal firm were discussed by members of the House, after which the following motion was made:

*The House of Delegates of the Rhode Island Medical Society instructs its elected representatives on the Board of the Hospital Service Corporation to request that Corporation to amend its by-laws to provide that only physicians having a certificate to practice medicine and surgery be declared eligible as contracting physicians under the Voluntary Surgical Insurance Plan.*

Dr. Pitts reported the result of the mail ballot to the House of Delegates for the purpose of electing nominees to be submitted to the Hospital Service Corporation for election as representatives of the Society on its Board of Directors. He stated that the following physicians had been nominated and subsequently elected by the Hospital Service Corporation: Drs. Samuel Adelson of Newport, G. Raymond Fox of Pawtucket, Frank W. Dimmitt, Albert H. Jackvony, Philip Batchelder and William P. Davis, all of Providence.

Dr. P. F. Harrington moved that the members elected by the Society to serve as representatives on the Board of Directors of Blue Cross be given the power to act for the House of Delegates in

matters regarding the Surgical Insurance Plan, and that they also report in writing on their work at each meeting of the House of Delegates. The motion was seconded and passed.

* * * * *

### *Meeting of the House of Delegates on March 3, 1946*

A special meeting of the House of Delegates was held on March 3, 1946. Mr. Saunders, executive director of Blue Cross, was invited to address the House, and he did so reviewing the position of Blue Cross as regards the fee schedule.

---

The House adjourned after moving that the seven representatives of the Society on the Board of Directors of the Service Corporation act as a committee to arrange a tentative fee schedule and then submit such schedule to the Society.

* * * * *

### *Special Meeting of the House of Delegates March 10, 1946*

At a special meeting of the House of Delegates on March 10, 1946, the question of a fee schedule was discussed by the members. Discussion was introduced relative to whether the proposed plan should be a service plan or an indemnity plan. A motion was made by Dr. Ashworth that before any action was taken on the adoption of a surgical plan, reconsideration be given to the advantages and disadvantages of both service and indemnity plans. The motion was seconded, and after lengthy discussion, it was defeated by one vote.

A motion was made that the House of Delegates take no final action on the problem of insurance until the Medical Society has had the opportunity to express itself; and further, that the House of Delegates carry out the wish of the Society when that wish is made known. This motion was seconded and after discussion it was adopted without a dissenting vote.

* * * * *

### *Special Meeting of the House of Delegates August 28, 1946*

A special meeting of the House of Delegates was called on August 28, 1946. At this meeting Dr. William P. Davis reported on the completed work of his committee and submitted printed copies of the indemnity schedule and the subscriber and physician's agreement which had been sent to each member of the House. The Committee asked to be discharged from its work and the House so voted.

The motion was made and seconded that the report of the Surgical Insurance Committee relative to the fee table and Physicians Contract and subscribers contract be accepted. The discussion that followed was highlighted by the following:

Dr. Earl Mara discussed the motion expressing the belief that the House should approve of the report but at the same time it should have assurance from the legal counsel of the Society on the technical phases of the contracts in order to protect the House of Delegates and the membership of the Society.

After discussion it was moved that the report of the Surgical Insurance Committee be accepted and approved by the House of Delegates provided the legal counsel employed by the Society approves the wording of the contracts and suggests any changes to safeguard the interests of the society; and provided further that Dr. Pitts be authorized by the House of Delegates to approve any suggested changes or additions as recommended by the legal counsel before the final draft is submitted to the Hospital Service Corporation with the complete approval of the House of Delegates. The motion was seconded.

The report of the Committee was then unanimously adopted.

The president called attention to the fact that at its March 10 meeting, the House of Delegates had moved that no final action be taken on the plan until it had been submitted to the entire membership. Then he asked for further expression of opinion. A motion was made, seconded and passed that the action taken on March 10 should be rescinded.

* * * * *

### *Meeting of the House of Delegates September 25, 1946*

At the regular meeting of the House of Delegates on September 25, 1946, the president reviewed the study of the subscriber's contract for the surgical insurance plan relative to the clause concerning the participating physician as raised at the special meeting of the House of August 28. He reported that in conference with Blue Cross executives he was informed that they intended that doctors of osteopathy be included in the plan; and that the clause noted in the subscriber's contract was specifically intended to rule out beyond question the possible inclusion of chiropractors.

Dr. Pitts explained that at the conference meeting with the Blue Cross executives to discuss the subscribers contract, he had made a point to the group that at no time has the medical profession considered the osteopaths as qualified as surgeons under the same standards as doctors of medicine.

Dr. Pitts inquired of the legal counsel if the Blue Cross could write separate contracts. Mr. Williamson reported that the Board of Directors of the Blue Cross has authority to make contracts with anyone under the provisions of the legislation.

After this and supplemental discussion, the following motion was adopted by the House:

*continued on next page*

*That the Rhode Island Medical Society will accept the surgical services rider to the subscriber's contract provided that Part VIII thereof, sections (a) and (b) are amended to read as follows:*

*(a) Participating Physician—The term "participating physician" shall mean any person duly licensed by the board of examiners in medicine under the laws of the State of Rhode Island to practice medicine and surgery, who has entered into a participating agreement with the Blue Cross.*

*(b) Non-Participating Physician — The term "non-participating physician" shall mean any person duly licensed by the board of examiners in medicine under the laws of the State of Rhode Island, or by any other comparable and duly authorized board of examiners in medicine in any other State, to practice medicine and surgery, who has not entered into a participating agreement with the Blue Cross.*

* * * * *

### *Meeting of the House of Delegates January 22, 1947*

The reply of Blue Cross to the request of the House of Delegates made at the meeting of September 25, 1946 was incorporated in a letter to Dr. Herman C. Pitts, president of the Society, dated January 16, 1947, abstracts of which follow:

"At the last meeting of the Executive Committee of the Blue Cross on January 9, 1947, which was attended by most of the doctors representing the Rhode Island Medical Society upon the Board, a thorough discussion was had of the entire problem of osteopathic participation in the proposed plan for non-profit prepaid surgical care."

"The plan, as developed by the Rhode Island Medical Society and the Blue Cross, has now progressed to the point where, if this one problem can be solved, steps can now be taken to put it into operation. We are all concerned primarily with the interest of the public, and hope that this service will be available to them soon. The public is entitled to expect us to find a solution without further delay.

"No one can doubt that all concerned have conscientiously sought a solution, each having in mind his own conception of the public good. Blue Cross does not seek to enter into a controversy or take sides in the two schools of the healing arts. We are primarily concerned in seeing that a workable program of non-profit prepaid surgical care is put into effect at the earliest moment possible.

"We understand that the Medical Society is seeking the same objective and that the only objection remaining is that the Society does not desire, by cooperating in the plan, to appear to lend its endorsement and approval to osteopathy. We believe that this objection can be met readily if the following program were to be adopted.

"We propose, in effect, that Blue Cross cooperate with the Rhode Island Medical Society in offering a program of prepaid, non-profit surgical care covering the services of doctors of medicine only along the lines previously outlined in our exchange of correspondence. The Blue Cross will also, upon its own account, offer a program paralleling and supplementing the Medical Society's plan, covering claims for surgical services rendered by osteopathic physicians. The Medical Society is to have nothing to do with the latter program, which will be administered solely by the Blue Cross. It will not in any sense have the endorsement of the Rhode Island Medical Society. In order to make this arrangement practicable and to keep operating costs within reasonable bounds, it will be necessary that both plans be operated by the same personnel and that benefits be paid from a common fund. It will not be practicable to keep separate records, or actuarily possible to set up separate reserves."

"We offer the above program as a means of meeting the objection voiced by the House of Delegates. . . . It is our sincere opinion that if we are not able to agree there is no point in pursuing the matter further along present lines and it would be better to seek a new approach."

(Signed)
Kenneth D. MacColl, President
Hospital Service Corporation of R. I.

---

The House of Delegates voted not to accept this proposal of the Blue Cross, and the following public statement was issued by the Society:

*"At a meeting of the House of Delegates of the Rhode Island Medical Society held January 22, 1947, a final proposal of the Blue Cross that it would run a supplementary plan to the medical society's proposed low cost prepayment surgical insurance program, utilizing the same personnel and the same commond fund, was not accepted. The Society voted to continue its efforts to accomplish its objective of providing the public with a prepaid surgical insurance plan.*

*"The Blue Cross proposal was that the Society cooperate in offering a parallel plan covering surgical care by others than doctors of medicine. The Society believes that it can properly be concerned only with offering a plan to cover that segment of the public who desire the services of doctors of medicine.*

*"The Society is conscious of its obligation to provide the public with the highest standards of professional competence possible. It can discharge that obligation in the proposed plan only when the service rendered is under its jurisdiction."*

---

In order to seek a new approach to the problem of placing a low cost prepayment surgical insurance plan before the public under the auspices of the Rhode Island Medical Society, Dr. Rocco Abbate moved

*That a committee of five members of the Society be appointed by the House of Delegates to study ways and means of putting into effect the Rhode Island Medical Society's proposed low cost prepaid surgical plan as of its own, or through the possibility of having private insurance companies take it over.*

The motion was seconded and adopted.

---

## PROVIDENCE RECREATION PROGRAM

The recent report of the Providence Recreation Advisory Committee makes interesting reading. The recreation program of the City of Providence in years past has been much neglected, the playgrounds have had little care and the city administration and the public have taken no pride in this civic activity. The advisory committee has made valuable recommendations of which the most important seems to be "We further recommend that the Mayor appoint a seven member advisory committee to meet monthly with the Director of Education." Such a civilian committee if properly chosen, with a member from every organization having the health and welfare of our child population at heart, should exert a most important influence upon the director and his associates. Such a committee should function as a liason committee between the Providence Recreation Department, the public, and the daily press. Individual citizens are too much concerned with their own private affairs to be much interested in a play program unless stimulated by the public press. Publicity is necessary.

The report further states that "The success of this recreation program will depend largely—almost entirely—upon competent, trained and experienced leadership." Theoretically this might be true but whether we like it or not, every city or state position the country over, regardless of the qualifications of the appointee, becomes a political appointment. Gradually the functioning of any department becomes entirely dependent upon the director. The public is eliminated, loses interest and an unhealthy spirit of indifference arises in the department itself. The present condition of the city's playgrounds bears mute testimony to such a sequence of events in Providence.

Good physical and mental health should result from a properly conducted play program. Teachers employed to carry on the work should be chosen not only for their ability to teach the subject associated with the program but for their training in the handling of children. The program should be continued both summer and winter; our indoor facilities connected with our schools are good.

The care of the summer playgrounds should be delegated to the various boys' organizations in the community served by the playground. Only in this way may we expect to stimulate a sense of pride in the children who use the playgrounds; these children should be taught that they are citizens of this city, that the grounds are their personal property and their interests are best cared for by themselves. A few years ago the vandalism which resulted in the destruction of much playground equipment was interpreted by those who read between the lines, as a psychological protest on the part of the boys involved, against the condition of the playgrounds and the inadequate equipment supplied for their entertainment. No normal child, girl or boy, will wilfully destroy property in which he has a feeling of personal interest and pride.

In November, 1946, the citizens of Providence voted in favor of a million dollar appropriation presumably for the building of four new public play fields, of five acres each. Three of these are planned for closely adjoining sections—Federal Hill, Olneyville and Mount Pleasant. The fourth has been allocated to South Providence. If all the money appropriated is to be used for these highly expensive playgrounds there will be nothing left for the repair and reconditioning of some of our already existing play areas. Play lots for children of five or under all over the city should be planted to grass, shade trees should be added and there should be benches for mothers and their little children. Anyone who has examined these play lots will realize how much attention they need.

The South Providence playground bounded by Prairie Avenue, Dudley and Somerset Streets can be enlarged and equipped at a relatively small expense. The playground on Valley Street can be made into a large area for recreation. There is an excellent but poorly equipped area at the junction of Admiral and Charles Streets which with almost no expense can be reconditioned; this part of the city has been neglected in the City's plans. There are many other smaller lots of land controlled by the City which can be improved at little cost. If,

*continued on next page*

however, the million dollar appropriation is all spent on four new playgrounds we will find ourselves in the same predicament as formerly with an excess of property inadequately equipped for the expanded future administrative program devoted to the mental and physical health of our child population. Only an enormous increase in the playground annual appropriation can begin to take care of the old as well as the newly planned areas of recreation. One well conducted playground is a great asset to any city but a dozen poorly managed grounds constitute a liability.

While on the subject of playgrounds let us not forget that the City of Providence has also appropriated a large sum of money for building projects. Neither the Roger Williams nor the Chad Brown building projects have any arrangements for the entertainment of the children inhabiting those projects. In the future let us hope that the planners of new projects will not forget this important addition to each housing project.

## SURGICAL MEETINGS

**Providence becomes the surgical center of New England this year as the result of the recent announcement of the American College of Surgeons that it will conduct its sectional meeting for the medical profession of the northeastern area at Providence on March 28 and 29. Previously the New England Surgical Society had selected Providence for its annual meeting to be held on October 3 and 4.**

## WELCOME HOME

The Rhode Island Medical Society reports the following Rhode Island physicians as honorably released from active duty, all of whom have resumed the private practice of medicine.

HARRY E. DARRAH, M.D., 42 Woodbury Street, Providence
HARRY HECKER, M.D., 172 East Avenue, Pawtucket
ALFRED E. KING, M.D., 175 Harris Avenue, Woonsocket
JAMES W. LENT, M.D., Main Road, Tiverton
ELIHU SAKLAD, M.D., 252 George Street, Providence



## STATES LAUNCH ANTI-POLLUTION DRIVES

**Extended programs to curb the 5.75 billion gallons of untreated sewage dumped every day into the nation's waterways are being launched on the interstate, state, and local level according to the American Public Works Association.**

**Stream pollution laws were strengthened recently in Mississippi, while in Texas pollution of public waters has been made a penal offense. Local pollution surveys are being made in Texas by the state health department to determine changes and improvements needed in city and industrial waste disposal facilities.**

**In Oregon, 64 cities now have definite plans for new sewage disposal plants and sewer systems. Bond issues for this purpose totaling $14,995,800 have been voted in 19 Oregon cities, while 35 cities have accumulated sinking funds for sewage disposal totaling $2,324,114.**

**The Michigan state planning commission, meanwhile, has accepted plans for $100 million worth of sewage disposal projects, according to a recent nationwide roundup of anti-pollution activity made by Sewage Works Engineering magazine. Many of the Michigan projects are ready for construction.**

**The Pennsylvania anti-pollution program is centered on industrial as well as other urban wastes. The state health department has ordered 508 cities and institutions and 352 industries to prepare plans for sewage and waste treatment. Mine operators and manufacturers are being required to treat all waste discharges.**

**In California, sewage disposal construction has highest priority under $90 million public works construction legislation approved this year. Massachusetts and Minnesota strengthened their anti-pollution laws last year, 91 cities in the latter state having taken action in 1946 to provide for new sewerage facilities.**

**Because watersheds observe no geographical boundaries, several interstate agencies are acting to help curb pollution. Among these are the Interstate Sanitation Commission involving New York, New Jersey and Connecticut, and the Interstate Commission on the Delaware River. Interstate pollution control operations along the Ohio are being coordinated by means of the Ohio River Compact.**

**More stringent pollution control legislation is being drafted in several states. Maryland's new Committee on Water Pollution will recommend stronger anti-pollution laws to the 1947 legislature, while in Rhode Island a report on pollution is being prepared for the governor. Similar action is being taken in New Hampshire, Vermont and New York.**

***—Bulletin, Public Administration Clearing House.***

# CLINICOPATHOLOGICAL CONFERENCE

***Rhode Island Hospital***

*Name:* J. D. C.
*Age:* 63
*Admitted:* August 31, 1945

This patient was admitted with chief complaint of abdominal pain and inability to urinate.

This patient states he has been unable to void for 12 hours prior to admission and he has had difficulty in starting his stream with oliguria for the past few weeks. Nine hours before admission, after a heavy meal of fish, he experienced sudden onset of hypogastric and periumbilical distress which soon became a pain, and this pain became increasingly severe and gradually became generalized. At the time of admission the pain was more marked in epigastrium. He had never had any cramps, no vomiting and had never any tarry stools, but just before the onset of his pain he had a normal bowel movement.

## *PAST HISTORY*

In the past six months this man has been having periumbilical distress coming on 20 minutes after meals.

## *FAMILY HISTORY*

Irrevelant.

## *PHYSICAL EXAMINATION*

Reveals an obese male in evident pain. He is slightly cyanotic and sweating. *Head:* Negative. *EENT:* Not remarkable. The *lungs* are clear to percussion except for occasional moist rales at the left base. The *heart* borders are not percussible. No irregularities or murmurs. Sounds are distant, not very well heard. Blood pressure 90/60. *Abdomen:* This is moderately distended. There is voluntary spasm in the upper abdomen and in the region of the umbilicus. There is tenderness in the epigastrium. The abdomen is tympanitic in the lower half but not in the upper half which is dull to flat. There is diminished peristalsis. A fluid wave is also felt. *Rectal* examination reveals a large, firm prostate; no masses felt. *Extremities* show no abnormalities. *Reflexes* in order.

Admission Diagnosis:

1. Acute retention
2. ? acute pancreatitis
3. ? cholecystitis

## *LABORATORY WORK—AUGUST 31, 1945*

Blood urea nitrogen 22; glucose 132; creatinine 1.8. White blood count 8,350; 80% polymorphonuclears; 14% lymphocytes and 6% monocytes; hemoglobin 18.2.

## *PROGRESS NOTES*

*Surgical Consultation:* This 63-year-old white male was admitted to the Second Surgical Service with a history of sudden periumbilical pain following a supper of fish. However, the patient has a preceding history of difficulty in starting to urinate with oliguria and nocturia. The pain was more marked in the lower abdomen which gradually spread to the entire abdomen. Examination reveled a very distressed, toxic patient sweating; lips are slightly cyanotic and cold. The abdomen markedly tender, distended especially around and below the naval. There is dullness to flatness on percussion. Rectal reveals a soft, slightly enlarged prostate. Patient has history of not voiding since 2 p. m., August 30. I believe this patient is a genitourniary case and needs a suprapubic cystotomy.

Subsequent to admission the patient was catheterized with filliforms without success. Hot-Sitz baths and morphia were used to no avail.

*Genito-urinary Consultation—August 31, 1945—11:30 A. M.* This man has a good size prostate with a clot in his bladder. His bladder is palpable up to his umbilicus. He is in extremis, but cannot go on with his distended bladder. He was admitted to the Surgical Service eight hours ago—will accept on Genito-urinary Service.

*August 31, 1945*—2:00 P. M. Operation revealed no distention of the bladder. Peritoneal cavity was full of pus. Small rubber tissue drains were inserted.

*August 31, 1945*—3:00 P. M. Patient again seen by the Surgical Service. It was stated that at present his condition was too poor and will not tolerate operation. It was felt that the patient should be back into Fowler's position and a Levine tube substituted for Miller-Abbott tube. If the patient however, gets in operable condition, laparotomy should be performed. Condition at present is very poor. He is cyanotic and presents the blood picture of overwhelming sepsis.

*continued on page* 120


*Presenting*

**TWO FAMILIAR COMPOUNDS—COMBINED TO WORK TOGETHER**

# Neo-Synephrine *with* Penicillin

**FOR VASOCONSTRICTION AND ANTIBACTERIAL EFFECT IN ACUTE AND CHRONIC SINUSITIS**

| | |
|---|---|
| *Neo-Synephrine . . .* | outstanding among vasoconstrictors...in a new solution—especially prepared and *buffered* for use with penicillin. |
| *Penicillin . . . . . .* | "the best of the antibacterial drugs we now have for the local treatment of chronic sinus . . . infections."[1] |
| *In a Combination Package . . . .* | containing one vial each of dried calcium penicillin and specially buffered Neo-Synephrine Hydrochloride Solution ¼%...to be mixed just prior to dispensing. When mixed, each cc. contains not less than 1000 units of penicillin at pH 6.0. |
| *Special Buffer Action* | holds the pH at 6.0—optimal pH for maximum stability of penicillin in solution . . . physiologically approximating the slightly acid pH of normal, healthy nasal secretions. |
| *For Use . . . . . .* | in the treatment of acute and chronic sinusitis, by displacement, irrigation or tampon . . . full strength or diluted with one part normal saline. |
| *Supplied . . . . . .* | as combination package containing one vial each of dried calcium penicillin (approximately 15,000 units) and specially buffered Neo-Synephrine Hydrochloride Solution ¼% (15 cc.). Available on prescription only. |

*Trial supply upon request*

Frederick Stearns & Company
Division

DETROIT 31, MICHIGAN

New York • Kansas City • San Francisco • Atlanta • Windsor, Ontario • Sydney, Australia • Auckland, New Zealand

1 Ann. Otol., Rhin. & Laryng. 52:541, 1943.

*Neo-Synephrine* is the registered trade-mark of Stearns brand of Phenylephrine.

## CLINICOPATHOLOGICAL CONFERENCE

*continued from page 118*

*August 31, 1945.* Transfusion 1,000 cc. of plasma and 1,000 cc. of blood.

*August 31, 1945*—8:00 P. M. Color good in oxygen tent. He is responsive and states that he feels much better than he has felt all day. Pulse is good in quality and regular. Blood pressure ranges around 90/60. At present the abdomen is distended with gas. There is no board-like rigidity although tenderness and muscle spasm on palpation are noted throughout. It is most marked now in the right side in the paraumbilical area and right lower quadrant. The onset of the illness was gradual. Now that we know that he has had a peritonitis, acute appendicitis as the underlying cause would be the first choice.

*September 1, 1945*—1:30 A. M. Patient seen by the cardiac resident who states that patient is now in pretty fair shape so far as his heart and pulmonary circulation are concerned. It is advised that the IV's be kept below rate of 30 drips per minute to prevent failure.

*September 1, 1945.* Wasserman and Hinton negative. Urine 1017, protein 2+, sugar negative. Sediment shows red blood cells many, white blood cells few and many coarse granular casts. Transfusion—1,000 cc. of blood given. Blood urea nitrogen 39, sodium chloride 425, creatinine 2.5. White blood count 12,300.

*September 2, 1945.* Patient is stuporous which may be due to excess morphine. Moist rales are present at both bases and the abdomen is more distended today.

*September 2, 1945*—3:45. Patient suddenly turned blue, began to breathe with bubbling sounds. Chest was full of moist rales. Heart sounds were weak, the pulse was 72 but very thready. Blood pressure 50/20. This episode occurred minutes after an enema was given. Expired at 3:45 P. M.

* * * * *

*Dr. Edmund Laurelli:* The thing that interested me was that at no time did the man definitely have signs of a peritonitis; at no time did he have a board-like abdomen. He showed spasm and he had a good deal of tenderness, which became generalized.

In discussing differential diagnosis, I am going to take the premise that he had two conditions:

1. A genito-urinary condition, and
2. A separate condition involving the peritoneum and the abdomen itself.

I think that this excludes discussion of any medical possibilities. So that we come to the first consideration, which was acute appendicitis. The onset of acute appendicitis is usually quite insidious, and the initial epigastric pain is usually mild. However, this patient came in, cyanotic, and in shock, which was too soon, I think, for appendicitis as we usually see them. But, the previous history of dyspnoea suggested other possibilities.

The next possibility which was mentioned by the interne was acute hemorrhagic pancreatitis. We don't like to pay too much attention to that because it only accounts for one per cent of abdominal trouble, but the patients afflicted with this particular type of disease usually are obese and give a history of gall bladder disease.

The initial pain of pancreatitis is agonizing and is accompanied by signs of shock. Rigidity of the abdominal muscles is not as marked as a ruptured viscus. The tenderness, if any, is continued to the upper abdominal quadrants. Very often, in pancreatitis, a mass is felt in and around the epigastrium, and there is vomiting, which this patient did not have; those are the usual symptoms of pancreatitis. In fact, the vomiting is continuous and the retching may be intractable.

Another possibility which the interne considered in his provisional diagnosis was acute inflammatory process of gall bladder. This, again, is more of a compact, clinical quantity, which does not suggest itself in this particular case. There was no right upper quadrant pain, in spite of the indigestion he had. There were no local findings leading to the right upper quadrant, and no distribution of pain typical of the gall bladder.

The next consideration, not mentioned on the admission diagnosis, was mesenteric thrombosis. This man was 63 years of age, and no doubt had cardiovascular disease. He would be a set-up for that. But again, there wasn't the violent onset that you would get with that. There were no tarry stolls, diarrhea, colicky pain, no blood in the stools, which may occur. The pain in thrombosis is constant and diffuse, and the progress of the patient tends to get progressively worse.

Then, we must consider ruptured viscus, and perhaps first in that group, a perforated, peptic ulcer. The onset is sudden in this type of case. There is usually a history of distress. But the findings in this patient were more or less enigmatic, because of no board-like rigidity. It is possible that the picture was obscure because he came in, in a second stage of perforation, in the stage of reaction, where the patient looks a little better, his color has improved, his pain is lessened, and he has a little more euphoria; he feels better. That is the stage when the perforation is misdiagnosed. But, at this second stage, although the pain is still present, it is dulled,

*continued on page 124*

## CLINICOPATHOLOGICAL CONFERENCE

*continued from page 120*

and very often missed. There later develops a localizing pain in one of the lower quadrants, and in this case it was the right lower quadrant; this was found by surgical consultation. In fact, it was upon the right lower quadrant pain that the diagnosis of acute appendicitis was made, and is often mistakenly made, the reason being that the gastric contents, having spilled out into the abdomen, hit the transverse mesacolon and follow the ascending colon down to the right and there the gastric contents are pooled to form a localizing acute area.

It is with this thought in mind that I have ventured to say that the man may have had a perforated, peptic ulcer.

I should like to hear some comments on that.

DR. CLARKE: You would put peptic ulcer down as first choice, Doctor?

DR. LAURELLI: Yes, I would.

DR. CLARKE: What would be your second choice?

DR. LAURELLI: Mesenteric thrombosis.

DR. CLARKE: And you rejected the gall bladder and the apendicitis?

DR. LAURELLI: Yes. Those are the two possibilities, in the order of my preference.

DR. CLARKE: Is there any discussion on this story, from the clinical point of view?

DR. FREEDMAN: What was the cause of death? Pulmonary embolism?

DR. LAURELLI: Well, it could have been the straw that broke the camel's back. I think the man was sick with infection before he had anything else, so it could at least be a secondary cause.

DR. CORVESE: I think that from the complaints the man could have had anything. I think I favor the appendicitis. However, because of the progressive symptoms and the finding of pus, I think this man had a perforated ulcer, localizing abscess, and when he came in with signs of ruptured ulcer he was somewhat gone, so he didn't have a board-like abdomen, and he died from peritonitis and probably other complications, pneumonia, but did have probably a large prostate.

I think in spite of other signs that he had a ruptured duodenal ulcer.

DR. FREEDMAN: I am wondering about the urinary symptoms, irritation of the bladder, and the generalized peritonitis. My first guess would be a ruptured appendix.

DR. CLARKE: Is there any other discussion?

DR. GOLDOWSKY: I think there is the possibility of a neoplasm.

DR. CLARKE: Is there any further discussion? If not, we will report to you the post mortem findings, as far as we know them. We attempted, first, to dispose of the question of some terminal episode, apart from his primary illness, and here again we are a bit uncertain, although we assume that the absence of definite statements means they were not present.

A few things that have impressed me in the post mortem of both of these cases—and I am saying this largely for the benefit of my own staff, are the descriptions. There is no mention of the blood vessels in the post mortem examination. We don't know the finding on that; there is a definite lack of information there.

As far as we know, there was no terminal pulmonary embolism.

Now, the patient's abdomen had already been opened, and it was pretty well established that there was a generalized peritonitis; it remained only for the post mortem examination to reveal the sources of the peritonitis. The possibilities have been reviewed by Dr. Laurelli, and I am pleased to say that the one that he put at the top, peptic ulcer, is the one that was found at post mortem. This man had a peptic ulceration of the duodenum, which was a good-sized one, about 2 c.m. in diameter. This had perforated at the time of the post mortem. The entire peritoneal cavity was covered with purulent exudate, so the perforation which was now plugged with the omentum, had very definitely leaked at an earlier hour.

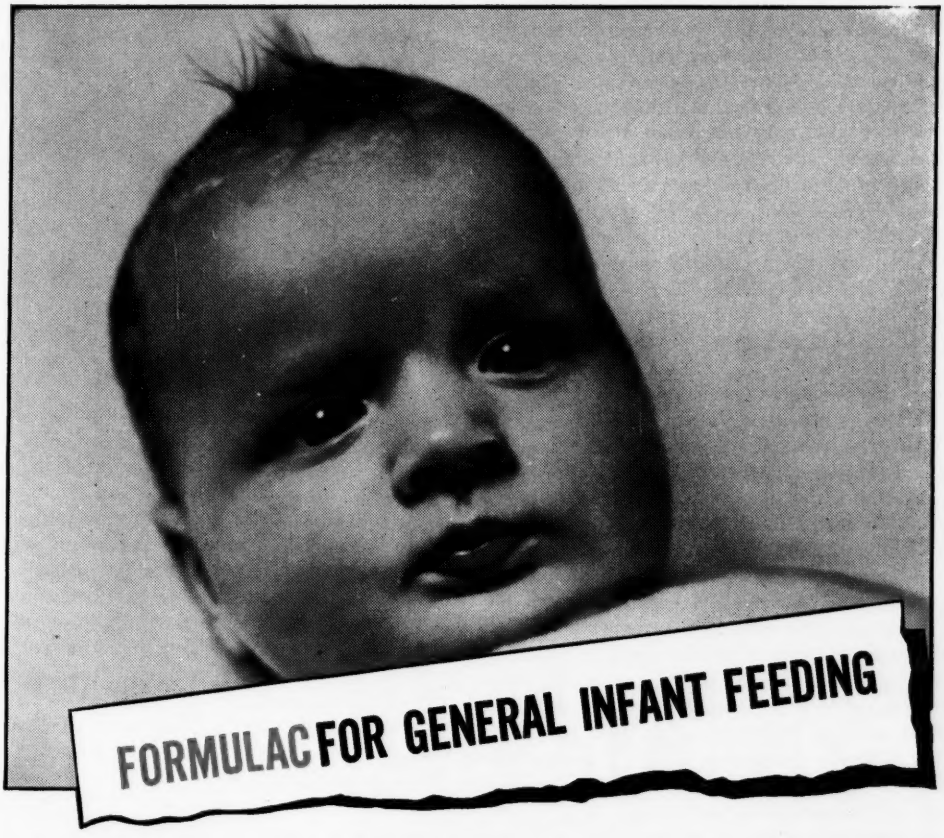
Now, in addition to the duodenal ulcer, this man had a second ulcer on the stomach side of the pyloric ring. This was a small, shallow ulcer, and only ½ c.m. in diameter.

The matter of the prostate remains again somewhat uncertain. The only statement regarded in the gross description is that the prostate is small. The bladder was not distended. I thought that I would take advantage of this opportunity to discuss rather hurriedly the pathology of peptic ulcers. The chief interest in connection with the peptic ulceration, I think, extends around the etiology. We could spend a lot of time discussing that. But we will confine our discussion to the description of the morphological changes. Ulcers of the peptic origin, of course, occur usually in the stomach or the duodenum. Other rare locations are the lower end of the oesophagus, and occasionally in the diverticulum; also occasionally in the jejanum, following surgical anastomosis, between the stomach and the jejunum.

The lantern slides which we present will be a mixture of duodenal and gastric ulcers, but you will find quite applicable to either one.

The location of the gastric ulcer is most commonly near the pylorus, and towards the lesser curvature side, and since this happens also to be the most common case for gastric malignancy as one of the reasons, there has been some suspicion

*continued on page 126*




FORMULAC Infant Food provides a balanced and flexible formula basis for general infant feeding – both in normal and difficult diet cases.

Developed by E. V. McCollum, FORMULAC is a concentrated milk in liquid form, fortified with all vitamins known to be necessary for proper infant nutrition. No supplementary vitamin administration is necessary with FORMULAC. The Vitamin C content is stabilized, assuring greater safety.

The only carbohydrate in FORMULAC is the natural lactose found in cow's milk—no other carbohydrate has been added. This permits you to prescribe both the amount and the type of carbohydrate supplementation required.

FORMULAC is promoted ethically, to the medical profession only. Clinical testing has proved it satisfactory in promoting normal infant growth and development. On sale in grocery and drug stores throughout the country, FORMULAC is priced within range of even modest incomes.

***Distributed by* KRAFT FOODS COMPANY**

**NATIONAL DAIRY PRODUCTS COMPANY, INC.**

**NEW YORK, N. Y.**

**• For further information about FORMULAC, and for professional samples, mail a card to National Dairy Products Company, Inc., 230 Park Avenue, New York 17, N. Y.**

## CLINICOPATHOLOGICAL CONFERENCE

*continued from page 124*

thrown upon peptic ulcer as a starting point for malignancy. By the time the pathologist sees these ulcers, they usually are rather deep and they extend, involving the stomach or the duodenum, as the case may be. Textbooks are very fond of describing them as being like stair steps, something like this (showing slide). It is true that they, occasionally, are stair steps, but more often they are cup-shaped or cone-shaped, rather than terraced, or stair-steps.

Along with the destruction of normal tissues, there is a defense reaction on the part of the body, which is a repair reaction, in the production of granular tissue which, as it becomes older, lays down cologen and becomes scar tissue. So that always, unless it is an acute ulcer, there is an advance of the actual defect with granular tissue, and then fibrous scar tissue. This may reach the proportions that the stomach or duodenal wall becomes many times its normal thickness.

The first lantern slide shows a gross specimen as an illustration of an ulcer of the duodenum, and this represents the pyloric range, and this is the gastric side of the material (indicating in slide). This is the duodenal ulcer. They tend to be rounded, although irregular in shape, rather punched out. The wall may overhang a little bit, on the gastric side, they tend to overhang in the upstream direction, and they slope off towards the pylorus. So that this is a rather typical appearance of a moderately sized and moderately deep duodenal ulcer.

This, likewise (showing slide) is a duodenal ulcer, this one being not so deep and not so much fibrous scar tissue.

This (showing slide) is, to all intents and purposes, much like the two we have just seen. This is located on the gastric side of the pylorus, and the walls of this are thickened; the defect extends entirely through the muscles, so the underlying tissue which you see in the bottom of the ulcer is fibrous scar tissue.

These have a tendency, when they are located at the pyloric ring, to extend so as to encircle the lumen, and here is an ulcer (showing slide); this is the pylorus, and this suggests the gastric side; this extends laterally, so that it encircles the entire lumen at that point.

Ulcers are not infrequently multiple. We have mentioned duodenal and gastric ulcers today. Here is a multiple ulcer (showing slide). And here is another example of multiple gastric ulcer (showing slide); these are acute ulcers. There is no fibrous reaction about them; they are all very acute, and they involve just the mucosa. These were found in a patient who post-operatively developed thrombosis of the splenic artery and the coronary arteries of the stomach.

When they extend through the wall, fortunately and not infrequently they do so adjacent to some other organ, and this reparative reaction is sufficient to sew the two structures together, so that while the stomach wall is entirely perforated, it doesn't leak into the peritoneal cavity.

The next slide shows a cross section through an ulcer, the purpose being to show first the shape and the depth of the ulcer crater; then to show the great increase in thickness of the wall about the ulcer, due to the laying down of the fibrous scar tissue.

Here is another one, and it is a poor photograph, but it shows the cup-shaped one, while the other is more cone-shaped.

This next slide represents a stomach, and on top of it, laid open, is the jejunum, and this is the orifice, and at the periphery of this orifice or near it is this great peptic ulceration in the jejunum.

Histologically, there is a characteristic picture that is found. There is a very low-powered and a small ulcer, so that we have all of the field, the mucosa almost overhangs, with a defect through it (showing slide). Since we can't see the muscle on either side, we don't know how deep this goes, from the section shown, but there is in the ulcer, and always there is on the surface, even when it is much larger, some exudate, and perhaps a little debris from intestinal contents, and beneath that, there is a layer of tissue, which is a cellular, stained with pink, and it represents the progressive digestion of tissue, and the gastric juices, and are spoken of as the peptic membrane. External to that is granulation tissue, and if you go further out, there is scar tissue.

Here is a photograph, or a photomictograph, showing one edge of it. This one slopes off slowly. It is a cup-shaped, rather than a cone-shaped ulcer, but there is no stair-stepping. It illustrates the exudate, peptic membrane, with granular tissue and scar tissue. The next slide shows you a higher magnification, which brings out better the pink staining peptic membrane and also in this magnification, I think you can see particularly here that this granulation tissue is extremely vascular; these little red spots (indicating) represent capillaries, and patients frequently have blood in the stool, although no gross hemorrhage.

The next slide shows a photomictograph of the same area, greatly enlarged, to show how very vascular the tissue is.

These ulcers tend to shield and in the histological preparations, the evidence we have of healing, is this. Of course, if the thing is attempting to heal on the surface, the epithelium from the adjacent one goes out over the defect, and we can see the epithelium standing out here in this particular specimen. There is a definite attempt at repair. It doesn't replace new ones, but it covers them only

*continued on page 128*

### CLINICOPATHOLOGICAL CONFERENCE

*continued from page 126*

with a layer of two or three rows of cells.

The complications of ulcers are, of course, perforation, as we have seen this morning, hemorrhage from larger vessels or from capillaries just seen.

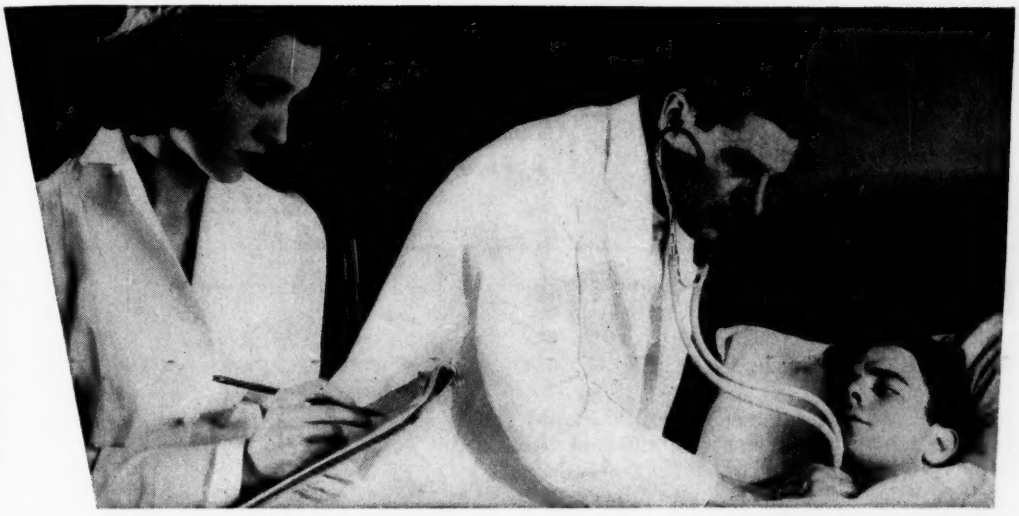
This is a large, gastric ulcer (showing slide), and in its base is exposed a very large artery, which proved to be the splenic artery, and there is a defect there. This patient died of hemorrhage around the splenic artery. More often, instead of such large vessels, you see on the base of the ulcer fibrous scar tissue and numerous little arteries here, and patient died of hemorrhage; you can see a hemorrhagic spot.

Upon histologic examination through such an artery, we see this picture (showing slide). Here is the vessel longitudinally, with blood in the lumen, and this is the ultimate base (indicating) and this opens directly in the lumen or the stomach.

Here is a duodenal ulcer, and the white that you see in the base this time is a white cloth, upon which specimen was placed. The external surface of the specimen, I show you here (showing slide).

Is there anything that you wish to add, Dr. Laurelli?

DR. LAURELLI: We had x-rays on the patient, but they were inconclusive at the time taken, and wouldn't have led to a diagnosis.



# "Bronchial Asthma ...etiology undefined"

In the paroxysms of bronchial asthma neither the physician nor his patient can wait for full identification of all asthmagens. *Without delay, symptoms must be relieved.*

PARASMA provides this rapid, symptomatic relief by the *oral* route. It is a synergistic combination of three principal oral antiasthmatics recognized individually in the *United States Pharmacopoeia.*

The combined PARASMA formula often succeeds where its components are ineffective singly, yet it does not involve the use of barbiturates, narcotics, pyrazolons or strychnine. On request, you will receive a free, full-size trade package of PARASMA for trial in your practice.

**Parasma is not advertised to the Laity**

Each PARASMA tablet contains ephedrine hydrochloride 1/8 gr., aminophylline 1 gr. and sodium bromide 3 gr. It is *indicated* in bronchial asthma to prevent or abort paroxysmal attacks and as a sustaining therapy.

# PARASMA

DOSAGE: *3 tablets with water. Not to exceed 5 tablets in 3 hours or 10 tablets per day. Intermittent courses of 5 days per week recommended. Caution — too frequent or protracted use may lead to bromism or anxiety symptoms. Contraindicated in cardiac or renal disease, hyperthyroidism, hypertension or diabetes.*

HOW SUPPLIED: *Bottles of 24 tablets.*

**for symptomatic relief of bronchial asthma**

CHARLES RAYMOND & CO., Inc., 381 Fourth Avenue, New York 16, N. Y. RIMJ-2

Please send literature and a free, full-sized trade package of PARASMA.

☐ I am also interested in colonic constipation therapy. You may include corresponding material on EMODEX.

*Dr.* _____

*Address* _____

*Town* _____ *Zone* _____ *State* _____

# PROVIDENCE MEDICAL ASSOCIATION

THE one hundredth annual meeting of the Providence Medical Association was held at the Medical Library on Monday, January 6, 1947. The meeting was called to order by Dr. Paul C. Cook at 8:30 p. m.

Dr. Cook announced that in view of the lengthy program planned the reading of the minutes of the previous meeting would be omitted unless there was a vote otherwise by the members present. The reading of the minutes was omitted.

Dr. Frank B. Cutts, Secretary, presented his annual report in which he reviewed the activities of the Association during the past year. Dr. Frank W. Dimmitt moved that the Secretary's annual report be accepted and placed on file. The motion was seconded and adopted.

In the absence of Dr. William P. Davis, Treasurer, Dr. Frank B. Cutts presented the annual report of the Treasurer. Dr. Robert R. Baldridge moved that the report be accepted and placed on file. The motion was seconded and adopted.

Dr. Frank B. Cutts reported for the Executive Committee as follows:

1. That no counter nominations to the slate of officers as presented to the membership by the Executive Committee had been received.
2. That the Executive Committee presented an estimated budget for 1947 for the Association in the total amount of $7,360.08 for which it recommended the assessment of annual dues of $15.00 for each active member and $5.00 for each associate member.

Dr. William M. Muncy moved that the budget as submitted by the Executive Committee be accepted and approved and that the dues as recommended by the Executive Committee be adopted for 1947. The motion was seconded and unanimously adopted.

3. That the Executive Committee recommends that the term of elected members to the Executive Committee of the Association be three years instead of five years, and therefore, it submits as an amendment to the By-Laws that the first paragraph of Section 8 of Article 1 should read as follows:

*"The Executive Committee shall consist of the President, the Vice President, the Secretary, and the Treasurer ex-officio, and of ten members elected by the Association. Members elected on and subsequent to January 6, 1947, shall be elected for a term of three years."*

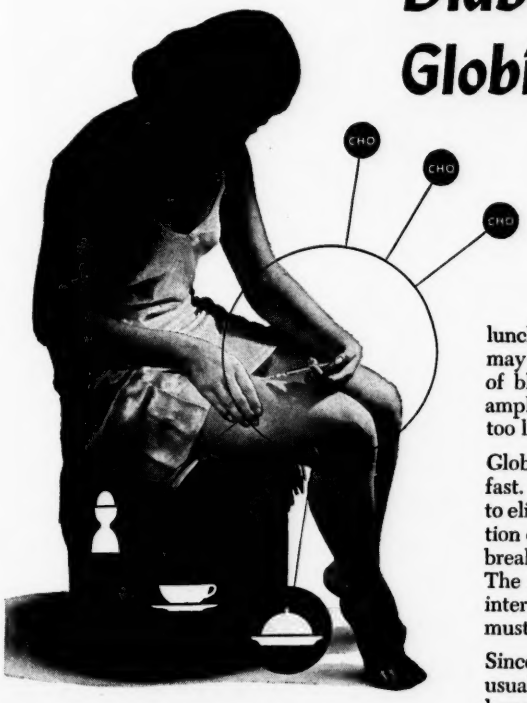
Dr. Frank W. Dimmitt moved that the proposed amendment to the By-Laws be adopted. The motion was seconded and unanimously passed.

Dr. Paul C. Cook delivered his presidential address on the topic of "Rhode Island's Water Pollution Problem."

*continued on page* 134

**GUY W. WELLS, M.D.**
**President, 1947**
***Providence Medical Association***

# Diabetes, diet and Globin Insulin . . .




THE ADVANTAGES of one-injection control of diabetes can, through adjustment of diet and dosage, be made available to the majority of patients requiring insulin. In view of the convenience and freedom afforded by the unique intermediate action of 'Wellcome' Globin Insulin with Zinc, the necessary adjustment is well worth while. Though not a complicated procedure, the regulation of carbohydrate balance warrants reiteration because of its importance:

**SOME FACTS ABOUT DIETARY ADJUSTMENT:** The distribution of carbohydrate in the meals must be adjusted in accord with the type of action exhibited by Globin Insulin, which is intermediate between regular and protamine zinc insulin. Proper carbohydrate distribution with proper insulin timing is essential; lack of balance may lead to poor control or to an erroneous impression of the characteristics of Globin Insulin.

A good carbohydrate distribution for the patient on Globin Insulin is to divide the total carbohydrate per day into 1/5 at breakfast, 2/5 at lunch and 2/5 at suppertime. This initial diet may be adjusted in accord with the indications of blood sugar levels and urinalyses. (For example, a low blood sugar before supper indicates too little carbohydrate for lunch or vice versa.)

Globin Insulin is ordinarily given before breakfast. Onset of action is usually sufficiently rapid to eliminate the need for a supplementary injection of regular insulin. However, the amount of breakfast carbohydrate should not be too large. The right amount, as well as the optimal time interval between the injection and breakfast, must of course be determined for each patient.

Since the maximum action of Globin Insulin usually occurs in the afternoon or early evening, hypoglycemia is sometimes noted at this time. As a guard against it, the carbohydrate content of the noon meal may be increased, or a midafternoon lunch provided. Thus the original distribution of 1/5, 2/5 and 2/5 might, for example, require adjustment to 2/10, 5/10 and 3/10 or to 2/10, 4/10, 1/10 and 3/10. Once the balance of carbohydrate intake and insulin timing has been established, the patient must be impressed with the importance of adhering to the regimen.

'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties. Available in 40 and 80 units per cc., vials of 10 cc. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No. 2,161,198. LITERATURE ON REQUEST.

*'Wellcome' Trademark Registered*

'WELLCOME' Globin Insulin WITH ZINC

BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 EAST 41ST STREET, NEW YORK 17, N.Y.

## PROVIDENCE MEDICAL ASSOCIATION

*continued from page 132*

After Dr. Cook's presentation a motion picture entitled "Clean Waters" was presented through the courtesy of the General Electric Company, demonstrating pollution in its various phases and means of combating it. It showed how sewage disposal plants worked. There are 6,000 in operation now in the country, but 10,000 more are needed.

Dr. Cook called for nominations for officers of the Association for 1947. Dr. Peter Pineo Chase moved that the Secretary be instructed to cast a unanimous vote for Dr. Guy W. Wells as President of the Association for 1947. The motion was seconded and passed. Dr. Cook appointed Drs. Herman A. Lawson and George W. Waterman as a committee of two to escort the new President to the rostrum. Dr. Wells briefly acknowledged the honor paid to him by the Association in elevating him to the Presidency.

Dr. Wells then called for nominations for the other officers of the Association. Dr. George Waterman moved that the entire slate as recommended by the Executive Committee be declared the elected officers of the Association. The motion was seconded and unanimously adopted.

Dr. Wells reported that the chairman of any committee might have the floor to amplify his report already made in writing which will be published in the RHODE ISLAND MEDICAL JOURNAL in the near future.

Dr. Peter Pineo Chase took the floor to briefly comment on the problem of water pollution and to introduce a motion from his committee with the recommendation of its adoption. The motion was as follows:

*WHEREAS the pollution of the waters of Rhode Island constitutes a health menace to the people of this State, and*

*WHEREAS this situation has been presented to the Providence Medical Association through its Committee on Water Pollution during the past year, and*

*WHEREAS Doctor Paul C. Cook, retiring President of the Association, has vividly reviewed the problem in his address this evening, and has pointed to the public apathy concerning the matter of pollution of our Bay and subsidiary waters, therefore,*

*BE IT RESOLVED the Providence Medical Association strongly protests the failure to eliminate such pollution, and also urges upon the Rhode Island Medical Society that it seek to arouse public interest in effective Statewide anti-pollution measures for the better health protection of the citizens of this State.*

As the motion was seconded, Dr. Wells called for a vote and the resolution presented by the Committee on Water Pollution was unanimously adopted.

Dr. Wells announced that the meeting of the Association on Monday, February 3, would be a joint meeting with the State Medical Society at which two outstanding physicians would address the membership.

Dr. Wells announced that the complete list of appointments to Committees of the Association for the year 1947 would be published in the MEDICAL JOURNAL and each man would be notified individually of his appointment.

Dr. Wells then introduced Dr. Alex M. Burgess who conducted a panel discussion on the "Residency and Fellowship Program at the Rhode Island Hospital." The following physicians participated: Charles L. York, M.D., Herbert F. Hager, M.D., Michael DiMaio, M.D., Wilbur Mantner, M.D., and William J. H. Fischer, M.D.

The presentations of the men were as follows:

Dr. York, Senior Resident, presented a paper on Homologous Serum Jaundice. A case was presented of a patient who died of hepatitis several months after receiving pooled plasma.

Dr. Herbert Hager presented a case of Mediterranean Anemia.

Dr. Michael DiMaio gave a talk on Liver Function in Congestive Heart Failure. He pointed out that changes in Bilirubin occur even in early stages of heart failure.

Dr. Wilbur Mantner presented his studies on liver function showing that fatty liver is common in disease, particularly Thyrotoxicosis and this leads to drop in plasma protein postoperatively.

Dr. William Fischer talked on Plasma Volume.

The meeting adjourned at 10:35 p. m.

Collation was served.

Attendance—105.

Respectfully submitted,

DANIEL V. TROPPOLI, M.D., *Secretary*

## PAWTUCKET MEDICAL ASSOCIATION

A regular monthly meeting of the Pawtucket Medical Association was called to order by the President, Dr. Kalcounos, at 9:00 p. m. Thursday evening, December 9, 1946, in the Nurses' Auditorium of the Memorial Hospital. The minutes of the previous meeting were read and approved.

The application of Dr. Louis E. Hanna for membership in the Association was submitted to ballot and unanimously approved. Applications for membership of the following physicians were read and referred to the Standing Committee:

*continued on page 136*

## PAWTUCKET MEDICAL ASSOCIATION

*continued from page 134*

Rocco Bruno, M.D., James G. Chapman, M.D., Nathan Sonkin, M.D.

Mention was made of a special accident and sickness insurance plan offered to the Association by the Loyalty Group Insurance Company. No action was taken on this.

A report from the House of Delegates of the State Medical Society was given by Dr. Earl J. Mara. Dr. Mara said that at the last meeting of the House of Delegates several problems were raised which were considered best solved by the individual state medical groups. He discussed the following:

1. The creation of a Women's Auxiliary in the Pawtucket Medical Association.
2. The question of increasing the yearly dues of the Rhode Island Medical Society to $40 yearly.
3. The pre-payment surgical plan forwarded to the Blue Cross which was held up pending the acceptance or rejection of including osteopaths in the group.

Dr. Kalcounos remarked that the plan for the Women's Auxiliary was patterned after the AMA Auxiliary and it was hoped that the wives of physicians might enlighten their respective women's clubs about current medical economic trends.

Dr. Krolicki made a motion that the Pawtucket Medical Association go on record as approving the work of the delegates on the state pre-payment surgical plan and as opposing the joining with osteopaths. The motion was seconded and passed.

Dr. Charles Farrell, speaking as state delegate of the American Society of Physicians and Surgeons, said that the National Association of Education, a group entirely unrelated to medical organizations, had sent to the High Schools of the country as a topic of debate the question of State versus Private Medical Practice. He asked if the Medical Society was interested in donating $50 as a prize for the best essay on such a topic, with the State Society to contribute a larger prize in the hope of stimulating high school students in the consideration of medical care. He added that he would be willing to contribute the $50 himself. Dr. Farrell also briefly discussed some of the activities of the A.S.P.S. in guiding medical legislation.

Dr. Frank Hanley made a motion that the Pawtucket Medical Association approve the essay contest but defer action until the attitudes of other medical groups in the state were considered. This motion was seconded and passed.

Dr. Frank Hanley then presented a film, "Doctors and Industry" following which the meeting adojurned and refreshments were served.

* * * * *

A regular monthly meeting of the Pawtucket Medical Association was called to order by Dr. Kalcounos at 9:00 p. m. in the Nurses' Auditorium of the Memorial Hospital.

Reading the minutes of the previous meeting was omitted.

The application of Bencel L. Schiff for membership in the Association was read and referred to the Standing Committee.

Dr. Kalcounos spoke briefly of Rhode Island Medical Society membership. He mentioned the fact that all but sixteen members of the Providence Medical Association belong to the State group.

Dr. Thad Krolicki introduced the guest speaker, Dr. E. Parker Hayden, Chief of the Rectal Clinic, Massachusetts General Hospital. His topic was "Diagnosis and Treatment of Common Ano-Rectal Disorders."

Following a preliminary discussion, the speaker presented a series of lantern slides illustrating some of the disorders mentioned, particularly carcinoma of the rectum.

Later Dr. Hayden answered numerous questions from the floor and many invited physicians participated in these remarks.

The meeting adjourned at 10:00 p.m.

Respectfully submitted,
KIERAN W. HENNESSEY, M.D., *Secretary*

# ANNUAL REPORTS FOR 1946

## PROVIDENCE MEDICAL ASSOCIATION

### ANNUAL REPORT OF THE SECRETARY

Providence Medical Association, January 6, 1947

During 1946 the Providence Medical Association held eight meetings of which one was a joint meeting with the Rhode Island Medical Society held in February. The attendance at the meetings averaged one hundred members. The topics presented and the speakers at the meeting were as follows:

January 7—Presidential Address. B. Earl Clarke, M.D.
"Pulmonary Embolism and Infarction." Benjamin Castleman, M.D., of Boston.

February 4—"Medical Care for the Veterans." Major General Paul R. Hawley, MC, assistant administrator of Veterans Affairs, Washington, D. C. "The Plan for a Voluntary Surgical Insurance Program for Rhode Island." Herman C. Pitts, M.D.

March 4—Panel Discussion: "Acute Respiratory Diseases." Alex M. Burgess, M.D.; Harold G. Calder, M.D.; Francis B. Sargent, M.D.; and Morgan Cutts, M.D.

April 1—Panel Discussion: "Experiences in World War II." Guy W. Wells, M.D.; Kenneth G. Burton, M.D.; Alphonse R. Cardi, M.D.; Samuel D. Clarke, M.D.; and Nicholas A. Pournaras, M.D.

May 6—Case Report: "Quartan Malaria Following Transfusion." William J. H. Fischer, Jr., M.D.
"Thrombo-Embolic Disease — Prevention and Treatment." Robert R. Linton, M.D., of Boston.

October 7—Case Report: "Congenital Anomalies of the Great Vessels." Eugene A. Field, M.D.
"Present Procedures and Problems in a Neuro-Psychiatric Out-patient Service." David G. Wright, M.D.
"Neuro-Psychiatric Disorders — Office and Hospital Treatment." Hugh E. Kiene, M.D.

November 4—"Medical Aspects of Atomic Bombings." Shields Warren, M.D., of Boston.

December 2—Case Report: "Simple Cyst of the Renal Pelvis." Vincent J. Oddo, M.D.
"Treatment of Hypertension with Rice Diet." Fritz Behrendt, M.D. and Alex M. Burgess, M.D.
"Primary Bronchogenic Carcinoma," Joseph N. Corsello, M.D.

The Executive Committee of the Association met regularly during the year to transact the business of the Association and to initiate proposals to the membership at regular meetings. Highlights of the 1946 year included the formation of a committee by the State Medical Society to improve medical-dental relations, a study of the feasibility of a central telephone exchange, a survey of membership to secure a listing for emergency home calls either night or day, a review of the fee schedule for home and office visits, the awakening of public interest in the need for a more effective smoke ordinance, the opening of the Medical Library three nights each week, the microfilming of some of the Association's early records, efforts to secure office space for physician-veterans and for the removal of the zoning restrictions in some areas, the waiver of dues for physician-veterans for a period of six months after return to private practice, the continuance of display advertisements in the *Providence Journal* announcing the return to practice of members who had served with the armed forces, and the successful annual dinner and golf tournament held last fall.

The membership has continued to increase, with a total of 594 recorded at the end of the year. This number breaks down into 575 active members and 19 associate members. Thirty-four members were elected to the Association in 1946, six were granted a leave of absence, five transferred to other medical societies, one member was re-instated, three were granted associate membership, one was retired, and four were dropped.

During the year the following members of the Association died:

Michael B. Milan, M.D. (January 20)
Edward Campbell, M.D. (January 26)
John M. Peters, M.D. (January 27)
Raymond G. Bugbee, M.D. (February 3)
Michael J. O'Neil, M.D. (February 2)
Alanson D. Rose, M.D. (February 19)
Howard Keefe, M.D. (March 13)
James A. Gilbert, M.D. (May 17)
Dennett L. Richardson, M.D. (September 6)
Irving S. Cook, M.D. (September 9)

Finally, I wish to thank our executive secretary for carrying most of the onus of my office. A fact is worth emphasizing that by now must be quite evident to our membership—namely, the increasing value of the executive secretary to our organization. In these times when, to protect the public and ourselves, we must consider complex political, economic and legislative problems on a local and a national scale, his office has collected and has on file a large amount of helpful data. He has made many valuable contacts with newspapers, legislators, public officials and various national organizations. With him and his office we are prepared to meet the problems that face us. I believe our Association owes much to the late Dr. William Streker for his vision and energy in creating the office of executive secretary, and to Mr. Farrell for his efficiency and industry in filling it.

Respectfully submitted,

FRANK B. CUTTS, M.D., *Secretary*

January 6, 1947

### ANNUAL REPORT OF THE TREASURER, 1946

Providence Medical Association

| | | |
|---|---|---|
| RECEIPTS | | |
| Cash on hand, January 1, 1946 | | $1,658.72 |
| Memembership dues— | | |
| Payments on 1945 dues | 120.00 | |
| Payments on 1946 dues | 5,940.50 | |
| Payments on 1947 dues | 57.50 | |
| Dividends from investments | 47.50 | |
| Cash Assets | | $7,824.22 |

*continued on page 142*

# EXPERIENCE TAUGHT MILLIONS

## the Differences in Cigarette Quality

*...and now the demand for Camels— always great—is greater than ever in history.*

DURING the war shortage of cigarettes ... that's when your "T-Zone" was really working overtime.

That's when your Taste said, "I like this brand"... or..."That brand doesn't suit me." That's when your Throat said, "This cigarette agrees with me"... or..."That one doesn't."

That's when millions of people found that their "T-Zone" gave a happy okay to the rich, full flavor and the cool mildness of Camel's superb blend of choice tobaccos.

And today more people are asking for Camels than ever before in history. But, no matter how great the demand:

***We do not tamper with Camel quality. We use only choice tobaccos, properly aged, and blended in the time-honored Camel way!***



R. J. Reynolds Tobacco Company
Winston-Salem, North Carolina

## ANNUAL REPORTS

*continued from page 138*

EXPENDITURES

| | |
|---|---|
| Committees | $100.00 |
| Collations | 475.00 |
| Purchase of Journals and books | 429.19 |
| General Expenses | 1,069.18 |
| Opening Library Nights | 177.00 |
| Office Supplies and Equipment | 191.41 |
| Printing and Postage | 275.32 |
| Rhode Island Medical Society (Use of building, insurance, etc.) | 778.08 |
| Salaries | 3,152.46 |
| Taxes (Withholding on wages) | 342.31 |
| Telephone | 169.82 |
| Total Expenses | $7,159.77 |
| Cash balance, January 1, 1947 | $ 664.45 |
| Membership dues outstanding | 140.00 |
| *Investments* | |
| U. S. War Savings Bonds | $2,740.00 |
| Total Assets, Jan. 1, 1947 | $3,544.45 |

Respectfully submitted,

WILLIAM P. DAVIS, M.D., *Treasurer*

### AIR POLLUTION

The Providence Medical Association began its study of the problem of air pollution within the greater Providence area in January, 1945. In April, 1945, a Planning Committee proposed an up-to-date improved air pollution ordinance to facilitate law enforcement. (At the "Better Providence Meeting," sponsored by the Chamber of Commerce, held October 17, 1945, several endorsements were made relating to the control of air pollution, among which was the suggestion that the mayor appoint an advisory committee to review the present smoke abatement ordinance or a new ordinance.) A Civic Committee was appointed by Mayor Roberts in November, 1945, and this committee, after considering this situation, voted that the present ordinance was inadequate. In March, 1946, an Enabling Act, which came out of the Providence Medical Association's Subcommittee on Air Pollution was endorsed by the Civic Committee. It was felt that it would pave the way for a modern improved ordinance, and be flexible enough to allow other communities in the state to set up individual ordinances for protection against local conditions. In April, 1946, the above Enabling Act was passed by the General Assembly. In September, 1946, a model ordinance, published by the American Society of Mechanical Engineers, was presented to Mayor Roberts, and adoption urged by the City Council. This ordinance is a comprehensive and modern form of regulation, which, if enforced, would control the air pollution situation in the city of Providence. This ordinance passed a first reading of the City Council, but at the meeting of November 19 it was decided to present this problem at a public hearing, and the date set for December 2.

The public hearing was held at City Hall December 2, 1946. At this hearing the new ordinance was thoroughly examined. Several suggestions and changes were introduced by the members or representatives of industrial groups present, and the ordinance was held up. Subsequently, the Civic Committee met with representatives of industrial groups on December 9 and 16, and the ordinance was endorsed by the Committee and all concerned, after suggested changes had been incorporated into the ordinance.

It was now found that the ordinance could not be passed this year without calling a special Council meeting. The situation was discussed with Mayor Roberts, who said he would call a special meeting if our group so petitioned, but that the wisdom of this procedure for one ordinance might be questioned. The Mayor stated that he was personally in favor of the ordinance, and felt that he could almost guarantee that it would be passed early this coming year.

Professor Kissler, chairman of the Civic Committee on Air Pollution, appointed by Mayor Roberts, met with your chairman and in view of the situation as presented, it was thought wise not to press for a special meeting at this time, but to expect early 1947 action on the new ordinance by the City Council.

EDWARD S. CAMERON, M.D., *Chairman*
FRANK M. ADAMS, M.D.
B. EARL CLARKE, M.D.
ALEX M. BURGESS, M.D.
ANTHONY CORVESE, M.D.

### READING ROOM

The Reading Room Committee of the Providence Medical Association authorized the purchase of thirty-seven periodicals for the Medical Library during 1946. Of these, four were published in England; thirty-three in the United States. One new journal, OCCUPATIONAL MEDICINE, was added this year.

Six of the journals are in the field of general medicine; the remainder are divided among nineteen different specialties.

The Association has paid for the binding of eighty-six volumes and forty-nine are at the bindary at the present time. Binding continues to be a slow process, due to a shortage of skilled labor, but the Barnard Company has managed to keep up its high standards of workmanship and materials in spite of wartime difficulties.

Evening hours at the Library were started April 16th and continued through June 13th when the summer schedule went into effect. They began again on September 17th and are continuing at present. The Library has been open a total of fifty-nine nights and has had sixty readers. In the period from September 17th through December 19th, twenty-five of the visitors have been doctors; twelve, laymen.

ROBERT R. BALDRIDGE, M.D., *Chairman*
KENNETH G. BURTON, M.D.
ROBERT G. MURPHY, M.D.

### ADVISORY COMMITTEE OF THE COMMUNITY WORKSHOPS, INC.

There has been no occasion to hold a meeting of the entire committee during 1946. The Executive Committee of the Community Workshops has consulted the chairman of your committee on occasion, and members of your committee have assisted the Community Workshops in a number of matters which did not require concerted action.

CLIFTON B. LEECH, M.D., *Chairman*
RAYMOND F. HACKING, M.D.
WILLIAM A. HORAN, M.D.
LOUIS B. SAGE, M.D.
NATHAN A. BOLOTOW, M.D.
CATHERINE ZOURABOFF, M.D.
JOHN LANGDON, M.D.

*continued on page 144*

# *Announcing Crystalline Penicillin G Sodium Merck*

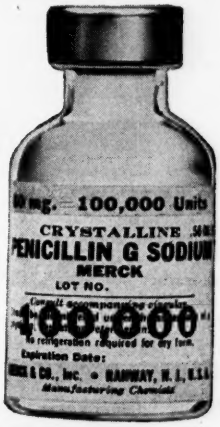
★ No refrigeration required for dry form.

★ Therapeutically inert materials which may act as allergens have been virtually eliminated.

★ Minimum irritation on injection as a result of removal of therapeutically inert materials.

★ Meets exacting Government specifications for Crystalline Penicillin G.

★ Penicillin G has been proved to be a highly effective therapeutic agent.




**CRYSTALLINE PENICILLIN G SODIUM MERCK**

MERCK & CO., Inc. RAHWAY, N. J.

*Manufacturing Chemists*

MERCK MERCK

## ANNUAL REPORTS

*continued from page* 142

### NURSING

The Committee on Nursing, as in the past, has been an advisory one principally to the Providence District Nursing Association. It has not met formally this past year, but its members have been consulted on occasions about problems concerning the Association.

KALEI K. GREGORY, M.D., *Chairman*
HENRY E. UTTER, M.D.
JOHN G. WALSH, M.D.
ELIHU S. WING, M.D.
JAMES H. FAGAN, M.D.

### ENTERTAINMENT

The Committee on Entertainment has arranged and provided for the collation following each regular meeting of the Association. It is particularly grateful to our executive secretary, Mr. John E. Farrell, for attending to the details of this function.

It is happy to report that the annual dinner and golf tournament was held at the Wannamoisett Country Club on October 9, 1946. A record attendance of members and their guests was registered at the links as well as at the dinner. The President's Cup was awarded by our president, Dr. Paul C. Cook, to Dr. Harry E. Darrah for low net score.

Every member who attended the dinner was the recipient of a valuable and attractive door prize. The performance of a professional entertainer was received with considerable enthusiasm and enjoyment. All comment received by your committee was most favorable.

HERMAN P. GROSSMAN, M.D., *Chairman*
NATHAN BOLOTOW, M.D.
E. WADE BISHOP, M.D.
RALPH DILEONE, M.D.
CARL D. SAWYER, M.D.

### PHYSICIAN-VETERANS

At the close of the year all but approximately fifteen members of the Association have resumed practice or are pursuing postgraduate work under civilian jurisdiction after service with the armed forces. During the year the Committee, with authorization from the Executive Committee, published display advertisements in the *Providence Journal* under the caption, "Your Doctor is Back." These advertisements, paid for by the Association, appeared in the *Providence Journal* on November 22, 1945; December 25, 1945; January 20, 1946; March 3, 1946; April 21, 1946; June 23, 1946; October 6, 1946. It is the belief of the Committee that these displays have been most helpful to the individual physician as well as to the public, in view of the fact that many of the men returning from the armed forces have established their offices at new locations and have new telephone listings not published in the directory this year.

In conjunction with the Executive Office and the Executive Committee efforts were made to assist returning veterans in securing office locations. Real estate agencies throughout the city were appealed to, and a news story was published in the *Providence Journal* citing the need for office spaces. The Executive Office has been of great service to the physician-veterans individually in supplying them with information to assist them in re-establishing their private practice.

A subcommittee of the Executive Committee sought assistance from the City of Providence relative to zoning

*continued on page* 146

## ANNUAL REPORTS

*continued from page* 144

restrictions in certain areas where physicians desire to locate.

The Committee is aware of the fact that it has been limited in its ability to assist every returning physician-veteran with his individual problem, but it has made every effort to place the facilities of the Association at the disposal of such men. The Committee feels certain that the work of the Executive Office has been appreciated by the physician-veterans.

ALBERT H. JACKVONY, M.D., *Chairman*
GUY W. WELLS, M.D.
RUSSELL S. BRAY, M.D.
HENRY S. JOYCE, M.D.
JAMES FALLON, M.D.
JAMES P. DEERY, M.D.
G. EDWARD CRANE, M.D.
E. WADE BISHOP, M.D.

## PRE-SCHOOL EXAMINATIONS

The major health activity of the Congress of Parents and Teachers, according to Mrs. E. Gardner Jacobs, health chairman in Rhode Island, is the so-called Summer Round-up or pre-school health examination project. The object of this activity is to prepare as many children as possible, physically, for their first years at school. To accomplish this aim, the parent-teacher organization has enlisted the cooperation of the school departments, local health authorities, medical societies, and private physicians, all of whom have been most generous in helping to develop a statewide pre-school health program.

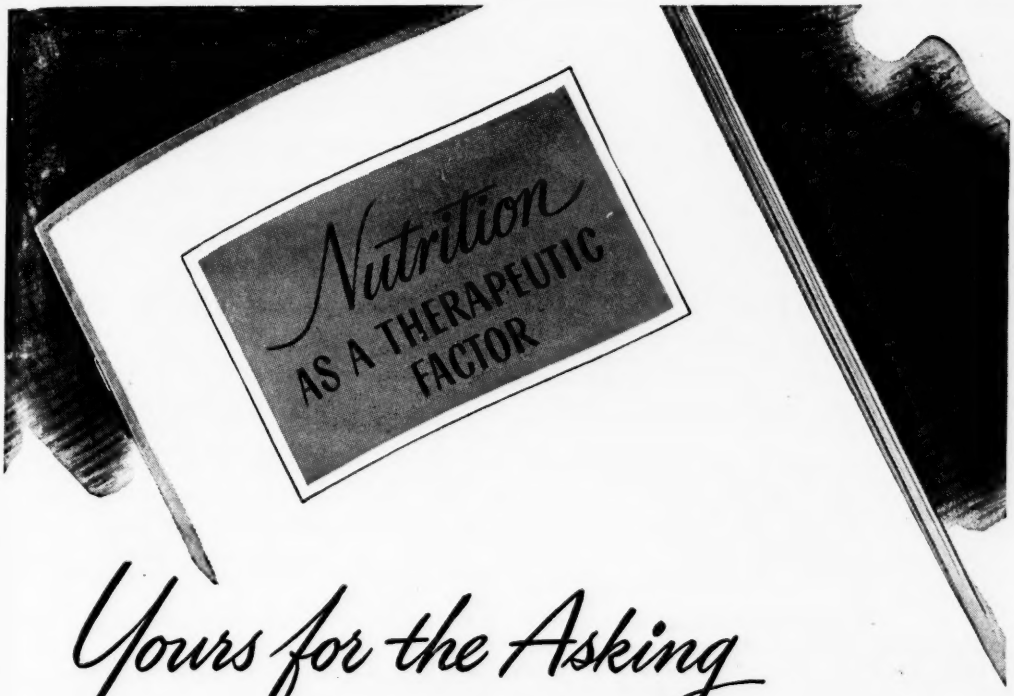
The type of Summer Round-Up program varies in different communities depending upon the need, facilities and personnel available. In general, the practice in smaller communities is to arrange for health clinics, where children are taken at certain specified times for examination, vaccination, and diphtheria immunization. In the larger centers, however, the usual procedure is for the examination to be made by the family physician in the spring or early summer preceding the child's entrance in school. This early examination is urged in order to give the physician time to correct any defects in the child's physical condition during the summer.

In Providence, during the year 1945-1946, an admirable plan was developed by the school department in consultation with the parent-teacher organization. A series of spring meetings were planned in the schools for the mothers of all children who were to enter school in the fall of 1946. The purpose of these meetings was not only to increase the effectiveness of the Summer Round-Up program in Providence; but, much broader in scope, it was to prepare the children for their new life in school. Mothers were informed regarding the mental, social and physical adjustments the children should make as they entered school. Health, nutrition, school regulations, clothing, the child's mental adjustment, etc., were discussed, and were an invaluable aid to the mothers who attended.

Largely because of these meetings nine (9) elementary Parent-Teacher Association Units in Providence sponsored summer round-ups in 1946. Twenty-three (23) units in other parts of the State also developed similar programs, making a total of thirty-two (32) elementary units participating in this pre-school health project.

As might be expected, such a movement as Summer Round-Up has been one of slow growth, largely because many parents still do not understand that it is important to have their child examined *before* he enters school. They know that the school health department will give the child

*continued on page* 148




# Yours for the Asking

## THIS INFORMATIVE COMPENDIUM ON A TIMELY SUBJECT

PHYSICIANS are invited to use the appended coupon to request a complimentary copy of the new brochure "Nutrition As A Therapeutic Factor." In a terse, straightforward manner, this compendium of current thought presents the remarkable strides made during the last decade in the use of nutritional factors as therapeutic weapons. The presentation concisely outlines present aspects of nutritional therapy providing information and data valuable in everyday practice. The applicability of the various nutrients in the treatment of disease is presented, adding to the practical utility of the brochure. The Wander Company, 360 North Michigan Ave., Chicago 1, Illinois.

**THE WANDER COMPANY, 360 N. MICHIGAN AVENUE, CHICAGO 1, ILLINOIS**
Gentlemen: You may send me a complimentary copy of "Nutrition As A Therapeutic Factor."

_____ M.D.

*Address* _____

*City and State* _____

## ANNUAL REPORTS

*continued from page* 146

a physical check-up during his first year of school, so many prefer to wait until then. Experience has shown, however, that when the child is not given a pre-school health examination, the correction of defects usually is deferred until the child is well along in school, handicapping him unnecessarily during his early school years, and making the defect more difficult to correct as time goes on.

Although the pre-school examination is not as prevalent as we would like, we are greatly encouraged by the generous support and cooperation in the movement by school and medical authorities, by an increasing awareness of its importance by the general public and by the yearly increase both of P. T. A. units sponsoring Summer Round-Up, and of parents participating in its program.

The committee of the Association serves mainly as an advisory group on the medical procedures involved in the pre-school round-up. During 1946 it was not necessary to hold any meetings. The results of the 1946 campaign will be tabulated later.

CHARLES B. LEWIS, M.D., *Chairman*
ROBERT M. LORD, M.D.
MERLE M. POTTER, M.D.
MICHAEL J. NESTOR, M.D.
TEMPLE BURLING, M.D.
LINLEY C. HAPP, M.D.

## WATER POLLUTION

The Committee on Water Pollution which was appointed last winter held several meetings. Fortunately, we got in contact with Mr. Robert S. Preston who was Secretary of the Committee on Water Pollution of the State Planning Board, which Committee was active for several years before the War. He gave us access to their records and we soon learned the more important aspects of the situation.

The problem is an enormous one. It will take many millions to make our waters reasonably clean. The engineering firm who were considered for making a survey and determining the major details of the problem asked over $100,000 just for this.

It was evident that the situation presented an analogy, to Calvin Coolidge's minister who preached on sin and was "agin" it. So we are all against water pollution. So far, both problems are unsolved in Rhode Island.

The Committee made a report which the press was pleased to publicize widely. This report presented no new facts but it talked frankly. One of their statements which was sharply criticized in the press at that time has now been verified officially within a few days. The details of all this will be discussed later this evening.

It really looks as though public opinion might now be aroused to the point where in a reasonable length of time oil, chemicals, and liquid feces may be kept out of our formerly healthy and beautiful Bay.

PETER PINEO CHASE, M.D., *Chairman*
EDWARD S. CAMERON, M.D.
ANTHONY V. MIGLIACCIO, M.D.

## TUBERCULOSIS

The Committee has had four meetings during the year. The following topics have been the main subjects of discussion:

1. The status of care of tuberculosis in Rhode Island
2. Tuberculosis education
3. Tuberculosis case-finding and control programs in the hospitals of Rhode Island.

There are many problems that militate against the ideal functioning of the State Sanatorium, some of which are beyond immediate control, the chief of which is ap-

*continued on page* 150

## ANNUAL REPORTS

*continued from page 148*

parently economic. This economic problem concerns both patient and hospital personnel. Many patients refuse proper care because adequate support for their families cannot be obtained during the period of enforced rest. Because of the scarcity of trained personnel of all types and the rising wage scale, there is a serious problem in maintaining desired facilities. It is felt that the hospitals for acute diseases in the state could relieve the pressure considerably if they would carefully rule out non-tuberculous disease before requesting transfer to the Wallum Lake Sanatorium. There is also the problem that an appreciable number of patients are by personality not adaptable to institutional care. Family physicians and social workers can be of vast assistance in many cases by familiarizing themselves with the sanatorium and home problems and assisting the patients and their families in meeting them. Frequently, careful explanations and encouragement go a long way in alleviating trying circumstances. More general cooperation of the physicians and patients of the state with the health authorities would greatly facilitate the follow-up of known cases of tuberculosis.

To assist in the education of medical personnel in training in Rhode Island, your Committee sponsors the circulation to the resident staffs of hospitals and to Medical Libraries two pamphlets, "Chest X-ray Interpretation" by J. Burns Amberson, Jr., and "Diagnostic Standards and Classification of Tuberculosis" published by the national society. To further education in regard to tuberculosis in general, a search is being made for a public relations man to work on this phase in Rhode Island.

The plan of the Rhode Island Tuberculosis Association to send copies of "Tuberculosis Abstracts" to the physicians of the state was discussed and approved. This was formerly sent out with the RHODE ISLAND MEDICAL JOURNAL but it became impossible to continue this practice.

The matter of hiring a public relations expert for furthering the work of tuberculosis in the state was discussed with the conclusion drawn that this would be a very valuable move if the proper person were available. The Rhode Island Tuberculosis Association has expressed its willingness to provide a sum of money for the salary of such a man, at least for a trial period.

A survey of case-finding programs for nurses in six hospitals in Rhode Island was presented. It was gratifying to learn that all six hospitals had some form of program, but most of them were inadequate according to present accepted ideals. Only half of them had routine x-rays of students more frequently than annually. Only two mentioned tuberculin tests, and one of these did only annual tests, while the other had tests every four months, on non-reactors. Four of the hospitals stated that graduate nurses were x-rayed annually, whereas in the other two there was no regular routine x-raying during their employment.

Since it is felt that hospitals should be the models for case-finding programs, it was decided that the committee should, at its January meeting, draw up an outline of a satisfactory program. This is to be sent to each hospital in the state with the recommendation that it be followed as closely as possible. In addition to the case-finding programs, recommendations as to tuberculosis control will also be sent.

*continued on page 152*

# Darthronol


**presents in a single capsule adequate potencies of the nine vitamins which repeatedly have been reported to play an important role in the management of the arthritic patient.**

## EACH CAPSULE CONTAINS:

| | |
|---|---|
| Vitamin D (Irradiated Ergosterol) | 50,000 U.S.P. Units |
| Vitamin A (Fish-Liver Oil) | 5,000 U.S.P. Units |
| Ascorbic Acid | 75 mg. |
| Thiamine Hydrochloride | 3 mg. |
| Riboflavin | 2 mg. |
| Pyridoxine Hydrochloride | 0.3 mg. |
| Calcium Pantothenate | 1 mg. |
| Niacinamide | 15 mg. |
| Mixed Natural Tocopherols | 3.4 mg. |

(Equivalent in biological activity to 3 mg. of Alpha Tocopherol)

Through the pharmacodynamic and nutritional actions of its nine constituents, Darthronol not only exerts a beneficial influence on the typical involvement of the locomotor structures, but in addition is of value in the control of many systemic disturbances frequently encountered in the arthritic syndrome.

The comprehensive brochure "Systemic Therapy in the Arthritides" is available on request.

**J.B. ROERIG & COMPANY • 536 Lake Shore Drive, Chicago 11, Illinois**

## ANNUAL REPORTS

*concluded from page* 150

Moving pictures were presented depicting the use of photo-fluorographic machines in tuberculosis case-finding. The films were most interesting and instructive. Of particular interest was the ease with which large numbers of people can be handled. It has been found that it is unnecessary for patients to disrobe for the examination, thus saving a great deal of time. With the use of the automatic photo-timer, films of uniform density can be made without measuring the depth of chest. This alleviates the need of highly trained technicians in mass fluorography.

The Committee approved the motion that meetings be held at least four times a year, during the fall, winter, and spring months.

A previous motion that there be at least one talk on tuberculosis on the calendar of the local medical societies each year was again discussed and re-approved.

JOHN C. HAM, M.D., *Chairman*
U. E. ZAMRARANO, M.D.
PHILIP BATCHELDER, M.D.
JOHN PINCKNEY, M.D.
PETER F. HARRINGTON
FLORENCE M. ROSS, M.D.
JAMES P. DEERY, M.D.
FRANK E. MERLINO, M.D.


**HALLMARK AND PRICE TAG:** Economic conditions have shown many swings during the four dec ades of CAMP history. But in th rhythm and flow of changing co ditions, CAMP price tags alwa have been and always will be con scientiously based on intrinsic value, just as the credo and pledge of the CAMP hallmark always have been and always will be expressed in the superb quality and functional efficiency of CAMP products. All are the measure of true economy to the patient.

*Camp Anatomical Supports have met the exacting test of the profession for four decades. Prescribed and recommended in many types for prenatal, postnatal, postoperative, pendulous abdomen, visceroptosis, nephroptosis, hernia, orthopedic and other conditions. If you do not have a copy of the Camp "Reference Book for Physicians and Surgeons," it will be sent upon request.*

**CAMP** TRADE MARK **ANATOMICAL SUPPORTS**

S. H. CAMP & COMPANY • Jackson, Mich. • *World's Largest Manufacturers of Scientific Supports*

*Offices in* CHICAGO • NEW YORK • WINDSOR, ONTARIO • LONDON, ENGLAND

# REPORT OF THE MILK COMMISSION OF THE PROVIDENCE MEDICAL ASSOCIATION 1946

CERTIFIED MILK in Providence during 1946 was obtained from the following farms: Cherry Hill Farm, North Beverly, Mass.; Fairoaks Farm, Lincoln, R. I.; Hampshire Hills Farm, Wilton, N. H.; Walker-Gordon Farm, Charles River, Mass.

Through the courtesy and co-operation of the Boston Commission we have accepted their certification of two farms from Massachusetts and one from New Hampshire.

Bacteriological and chemical examinations of certified milk are made in the laboratories of Brown University under the supervision of Professor Charles Stuart.

All of the herds are under State and Federal supervision and are free from Tuberculosis and Brucella abortus infections.

Much credit is due the management of these farms in keeping the standards of Certified milk on a high plane and these high ideals have been realized in spite of the acute shortages in materials and labor.

It is the hope of the Commission that new and better equipment will be installed during the year, as better materials become available. This will enable the farms to do even better jobs than has been possible the past few years.

During the summer our Commission entertained the Boston Commission and several of our local physicians. Mr. Alfred Cook of the Borden Company of New York gave an interesting talk on the future of Certified Milk.

During December reprints of an article, "Why Certified Milk," written and published by Professor Brown, of Johns Hopkins, was sent to every member of the Providence Medical Association and the Rhode Island Medical Society.

During the past year the Commission has carried one-half page advertisements in the R. I. MEDICAL JOURNAL in an attempt to keep the "Quality Milk" before the medical profession.

The Commission is indebted to Dr. Edwin Knights, Deputy Inspector of Milk in Providence, for his continued interest and advice during the past year.

HAROLD G. CALDER, M.D., *Chairman*
THOMAS J. DOLAN, M.D.
JOHN LANGDON, M.D.
FRANK I. MATTEO, M.D.
WILLIAM P. SHIELDS, M.D.
HENRY E. UTTER, M.D.
GEORGE W. WATERMAN, M.D.
RAYMOND L. WEBSTER, D.M.D.
REUBEN C. BATES, *Secretary*

## MONTHLY AVERAGES OF CERTIFIED MILK FOR 1946

| | CHERRY HILL H. P. HOOD | | | FAIROAKS | | | | | | HAMPSHIRE HILLS | | | WALKER-GORDON | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Pasteurized | | | Raw | | | Pasteurized | | | Pasteurized | | | Vit. D. Pasteurized | | |
| | B.F. | T.S. | Bacteria per C.C. | B.F. | T.S. | Bacteria per C.C. | B.F. | T.S. | Bacteria per C.C. | B.F. | T.S. | Bacteria per C.C. | B.F. | T.S. | Bacteria per C.C. |
| January | 3.9 | 12.50 | 60 | 4.2 | 13.17 | 2,300 | | | 101 | 4.1 | 12.90 | 165 | 3.7 | 12.50 | 84 |
| February | 3.7 | 12.33 | 85 | 4.1 | 13.03 | 3,457 | | | 186 | 4.1 | 12.95 | 498 | 3.7 | 12.51 | 70 |
| March | 3.6 | 12.20 | 105 | 4.1 | 12.89 | 3,150 | | | 380 | 4.1 | 12.96 | 215 | 3.9 | 12.55 | 100 |
| April | 3.6 | 12.16 | 39 | 3.9 | 12.70 | 3,100 | 3.7 | 12.43 | 713 | 3.9 | 12.69 | 157 | 3.6 | 12.36 | 110 |
| May | 3.7 | 12.19 | 41 | 4.0 | 12.79 | 4,233 | 4.1 | 12.82 | 400 | 4.0 | 12.73 | 218 | 3.7 | 12.46 | 138 |
| June | 3.5 | 11.97 | 36 | 3.7 | 12.44 | 4,275 | 3.3 | 11.84 | 469 | 3.9 | 12.60 | 232 | 3.6 | 12.10 | 141 |
| July | 3.5 | 12.01 | 28 | 3.8 | 12.52 | 2,338 | 3.5 | 12.10 | 687 | 3.8 | 12.53 | 198 | 3.8 | 12.38 | 121 |
| August | 3.8 | 12.30 | 21 | 3.6 | 12.23 | 3,478 | 3.6 | 12.19 | 151 | 3.9 | 12.57 | 445 | 3.8 | 12.40 | 101 |
| September | 4.0 | 12.43 | 14 | 4.2 | 12.86 | 3,563 | 3.8 | 12.28 | 256 | 3.9 | 12.37 | 101 | 4.0 | 12.53 | 41 |
| October | 3.9 | 12.27 | 16 | 4.1 | 12.76 | 4,347 | 3.8 | 12.26 | 90 | 4.3 | 12.84 | 86 | 4.1 | 12.79 | 46 |
| November | 3.9 | 12.24 | 40 | 4.1 | 13.03 | 12,664 | 3.7 | 12.30 | 128 | 4.0 | 12.54 | 157 | 4.0 | 12.64 | 46 |
| December | 3.9 | 12.45 | 59 | 4.1 | 12.78 | 5,760 | 3.8 | 12.39 | 88 | 4.0 | 12.51 | 137 | 4.1 | 12.64 | 42 |
| Yearly Average | 3.7 | 12.25 | 45 | 3.9 | 12.76 | 4,388 | 3.7 | 12.29 | 304 | 4.0 | 12.68 | 217 | 3.8 | 12.48 | 86 |